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Knowing in Childbirth

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KNOWING IN CHILDBIRTH

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
The Department of Curriculum and Instruction

by

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TABLE OF CONTENTS

| | |
|--|------|
| LIST OF TABLES | vii |
| LIST OF FIGURES | viii |
| ABSTRACT | ix |
| CHAPTER 1: STATEMENT OF THE PROBLEM..... | 1 |
| Introduction..... | 1 |
| Research Problem | 3 |
| Statement of Purpose | 3 |
| Significance of Study to Childbirth Education..... | 7 |
| Summary..... | 7 |
| CHAPTER II: REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK | 8 |
| Introduction..... | 8 |
| Learning about childbirth..... | 8 |
| Cultural and Social Contexts of Learning: Vygotsky..... | 9 |
| Language and Human Interaction: Bruner..... | 9 |
| Hermeneutic Phenomenology: van Manen..... | 10 |

| | |
|---|----|
| Woman to Woman Legacy: Davis Floyd..... | 11 |
| Review of Relevant Literature..... | 14 |
| Summary..... | 20 |
| CHAPTER III: METHODOLOGY..... | 23 |
| Research Design: Phenomenology..... | 24 |
| Hermeneutics..... | 27 |
| Feminist Knowing..... | 28 |
| Researcher Standpoint..... | 31 |
| Participants..... | 35 |
| Setting and Sampling..... | 35 |
| Data Gathering..... | 36 |
| Data Treatment..... | 38 |
| Reducing Bias..... | 38 |
| Ethical Considerations..... | 39 |
| Rigor and Trustworthiness..... | 39 |
| Delimitations..... | 40 |
| Summary..... | 41 |
| CHAPTER IV: PRESENTATION OF DATA..... | 42 |
| Description of Participants..... | 43 |
| Demographics..... | 46 |
| Findings..... | 49 |
| Knowing: Responding to Pregnancy..... | 52 |
| Unknowing: Disquieting Intuition..... | 57 |

| | |
|--|-----|
| Expecting Birth: Control..... | 62 |
| Expecting Birth: Hopefulness..... | 70 |
| Expecting Birth: Conflict..... | 72 |
| Expecting Birth: Confidence..... | 76 |
| Connecting and Disconnecting: Mother..... | 82 |
| Knowing: Birth Story..... | 85 |
| Knowing: Other Sources..... | 90 |
| Knowing: Barriers..... | 96 |
| Summary..... | 100 |
| CHAPTER V: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS..... | 103 |
| Limitations..... | 103 |
| Discussion..... | 105 |
| Conclusion..... | 116 |
| Implications for Childbirth Education and Research..... | 117 |
| Nursing Research..... | 118 |
| REFERENCES..... | 120 |
| APPENDIXES | |
| Appendix A Consent Form..... | 136 |
| Appendix B Introduction Letter..... | 139 |
| Appendix C Interview Questions and Demographic Form..... | 141 |
| VITA..... | 143 |

LIST OF TABLES

| | |
|--|----|
| Table 1: Age Distribution of Expectant Mothers..... | 46 |
| Table 2: Years of Education of Expectant Mothers..... | 47 |
| Table 3: Reported Weeks Gestation at Time of First Interview | 48 |

LIST OF FIGURES

| | |
|---|----|
| Figure 1: Knowing in Childbirth..... | 22 |
| Figure 2: Derivation of Themes from Expectant Mothers’ Lived Experiences of Knowing in Childbirth..... | 51 |

ABSTRACT

Research on knowing in childbirth has largely been a quantitative process. The purpose of this study was to better understand the ways nine, first-time mothers learn about birth. A phenomenological approach using a feminist view was used to analyze two in-depth interviews and journals to understand first time expectant mothers' experiences of knowing in childbirth. The findings demonstrated a range of knowledge that contributed to issues of control, confidence, hope, and conflict. The participants also described an increased dependency on their mothers and a lack of intuition contiguous to the birth process. These findings contribute understanding as to how expectant mothers know birth, suggesting that their knowing does not diminish conflict surrounding and may even exacerbate it. Childbirth educators may want to include instruction on negotiating power differential in relationships encountered during childbirth, and to assess the expectant mother's view of birth and her expectations for birth. Schools of nursing should consider the inclusion of women-centered care curricula in schools of nursing at both the undergraduate and graduate levels. Clearly, the politics surrounding birthing remain in place and must be removed to provide a supportive environment for normal birth.

CHAPTER ONE

STATEMENT OF THE PROBLEM

Introduction

*“The things we know best are the things we have not been taught.”
--Lae de Claipers Vauvenargues*

The sources of our knowledge surrounding childbirth are manifold. How do women, in particular, come to experience learning about birth? Kneller (1971) identified a trajectory of knowing that includes: 1) knowledge from a higher power that reveals truth and spirituality; 2) knowledge from within, insight or, intuition that is derived from experience; 3) knowledge from logical, rational thinking that evolves from abstraction; 4) knowledge from information that is tested and factual; and 5) knowledge from experts that is considered authoritative. All sources of knowledge are fruitful and vital to life experiences (Munhall, 2001).

Belenky, Clinchy, Goldberger, and Tarule (1997) profess that giving birth is a major life event for many women often accompanied by an “epistemological revolution” (p. 35) that is initiated by listening to others. Throughout time, knowledge about childbirth has been a measure of a woman-to-woman legacy (Boston Women’s Health Book Collective, 1979). For most women this traditional communication has been an influential way women learn about giving birth. We have a need to share real life experiences, our wisdom, and we have a need to learn from others (Broussard & Weber-Breaux, 1994; Dwinell, 1992; Zwelling, 1996).

The value of this type of personal knowledge has been critiqued by scientists who claim a sophisticated, advanced knowledge base. Such a dichotomy forces knowledge into superior and

inferior categories, thus fracturing traditional knowledge systems and accelerating their replacement by technology (Nakashima, Prott, & Bridgewater, 2000). Authoritative knowledge invariably supercedes personal knowing. In that process, a woman's knowledge of her own bodily functioning is often minimized and not valued (Hanson, VandeVusse, & Harrod, 2001). As modern women unwittingly distrust their intuition regarding ability to give birth, they begin the process of embracing authoritative, medical knowledge.

While women may possess a diverse array of medical information, they do not all necessarily know it in the same fashion. Experiential knowledge is gained from specific circumstances and from responses to symptoms and treatments. Responsively, knowledge filters and guides experiences. Medical knowledge exists within a specific context and is embedded within social relationships and interactions. Because there is inconsistency among knowers, issues of control and power are inherent in the childbirth process (Lazarus, 1997). Arguably, a feminist perspective of taking control of one's life and body should play a major role in decision-making related to birthing. One explanation for the rise of a middle-class, technocratic model of birthing, the medical model, is that feminist writing has limited itself to natural childbirth in opposition to technocratic birth (Lazarus, 1997, Nelson, 1986; Oakley, 1986; Romalis, 1981).

While story telling illuminates the subtlety and emotional components of birthing (Boykin & Schoenhofer, 1991), often it is not recognized as a source of legitimate knowledge (McHugh, 2001). Belenky et al. (1997) contend that motherhood profoundly and intricately connects the human experience. Inherent within this connection is knowledge, albeit a subculture of knowledge (McHugh, 2001). The distinctive emotional and spiritual essence of birthing has often been found lacking in formal childbirth education, therefore, its significance is even more critical in folk psychology, the knowledge that women pass from one generation to the next

(Negussie, 2001). Tritten (1992) describes women's wisdom surrounding birth as evolutionary. It is wisdom without voice until elicited by another woman. Confidence in one's ability to birth encourages sisters and daughters to share stories of celebration, strength, and wisdom (Noble, 1999; Tritten, 1991).

The purpose of this research is to better understand the ways first-time mothers learn about birth. The research problem I will focus on is: What are the experiences of learning (knowing) about birth for women? A brief history of childbirth education sets the stage for understanding the political and historical evolution of the dominant epistemology surrounding childbirth as it embodies prevailing cultural beliefs and thus serves to frame much of the research on the topic (Walrath, 2003). My review of literature and research evolve from this research problem as it relates to childbirth education, feminism, anthropological thinking, and applied educational theory with foundational concepts borrowed from Vygotsky and Bruner. The concept of phenomenology is discussed using van Manen's philosophy and theory.

A Brief History of Childbirth Education

Before the seventeenth century in Europe, men were legally barred from attending childbirth. Women surrounded the laboring woman, giving her support and a non-interventionist environment. Evidence of medical management began in the seventeenth century with the introduction of forceps (a well-kept Chamberlen family secret) and bloodletting to control hemorrhage. These interventions changed the tide of birthing as the experience, for the first time, came to be considered an illness (Ondeck, 2000; Phillips, 1999).

The environment of birth was again altered with the introduction of much needed asepsis and the use of chloroform in the 1850s and Fanny Longfellow's use of ether for childbirth in 1847. Keeping in mind that the Bible declared that women would suffer in childbirth because of

Eve's defiance in the Garden, the event signified the dilemma surrounding the moral role of pain in childbirth and the humane care of the expectant mother. Symptoms of economic changes that accompanied the industrial revolution in the nineteenth and early twentieth centuries included urbanization and separation of women from their families, communities, and midwives. To give birth in cleaner, safer environments, women moved their birth experience to hospitals. Hospital births dramatically increased from 10 percent in 1900 to nearly 99 per cent in 1979 (Zwelling, 1996). The medical field developed obstetrics as a specialty as women's confidence in their ability to birth declined. Now every birth was viewed as suspect and potentially life threatening (Ondeck, 2000).

Though the midwife had traditionally been seen as an integral part of community support for the expectant mother, from 1900 to 1930 midwifery almost died. At this time, women were having fewer babies and affluent women sought medical care, leaving midwives to care mostly for the poor. Moving to the hospital produced a sterile, lonely, controlled birth experience. With the turn of the century, anesthesia was widely accepted. One remedy for birthing in such a lonely environment with interventions that often included enema, episiotomy, and forceps was twilight sleep. From the point of administration, such a combination of drugs caused the mother to have amnesia of her labor and birth. Ironically, although women did not remember their experience, their response to the pain of labor was overt and often bizarre. To provide a safe environment for the over-medicated laboring woman, she was strapped in bed. Ironically, organizations were formed to force physicians to administer twilight sleep to their patients to stop maternal anguish. Although misguided, these organizations were considered the first advocacy group formed by feminist leaders to pressure doctors to change medical care (Pitcock & Clark, 1992).

In the 1950s, Pavlovian concepts were being applied in many arenas, including health

care. While visiting in the Soviet Union, Dr. Fernand Lamaze, a French physician, observed women giving birth without anesthesia. By Soviet dictum, women were trained to use relaxation and breathing patterns in response to their contractions. With a colleague, Pierre Vellay, Dr. Lamaze adapted these principles to the French culture. The French model of Psychoprophylaxis Method (PPM) included a series of paced breathing patterns that corresponded to labor progression. Focal points were used to enhance concentration. Lamaze's book, *Painless Childbirth*, was published in 1965 (Livingston & Dennedy, 2002). Simultaneously, the childbirth education movement was launched as different methodologies gained recognition (Bradley, 1965; Dick-Read, 1979; Kitzinger, 1981).

Even though little if any scientific evidence existed in the medical community as to the validity of these childbirth methodologies, mass communication introduced the ideas to the public to satisfy their desire for information on health care. Lamaze childbirth preparation was well received as women's groups began to examine the role of women in birth (Phillips, 1999). American Marjorie Karmel, a former patient of Dr. Lamaze, was frustrated trying to have a similar birth experience in the United States. She and Elisabeth Bing, the mother of American childbirth education, founded the American Society for Psychoprophylaxis in Childbirth (ASPO). The hope was that Lamaze would have long-lasting, positive effects on birthing (Karmel, 1959).

Social, political, and feminist issues shaped the adoption of the childbirth education movement largely by white, middle-class women. The supportive educational environment surrounding the teacher and learner in childbirth education may be ascribed to Alice Walker (1984). Walker's concept is derived from *womanism*, an African-American folk expression describing that which is spoken from mother to daughter. Williams (as cited in J. Taylor, 1998)

describes the responsibilities of a womanist to seek out the voices, wisdom, and experience of those women who are transparent in a male-dominated, technocratic society. It is in this attribute of feminine wisdom that Walker's concept womanism is most applicable to childbirth education.

Childbirth education should be based on best evidence about current health care practices. The Lamaze philosophy of birth claims belief in the wisdom of nature's plan for birth and women's inherent, instinctive ability to give birth that is evidenced-based (Lothian, 2001). Interestingly, the "best evidence" from research has given us a deeper understanding of nature's (woman's) wisdom and the impact of many current practices when it comes to birthing. Lothian (2001) defines best evidence as:

Best evidence has come to mean the specific effects, beneficial or harmful, of the various elements of care that may be carried out during pregnancy and childbirth—many of which reflect the medicalization of pregnancy and birth that has occurred over the last century. (p. 3)

Given that most studies have conflicting results and none recognized the impact of pre-existing knowledge, clearly this indicates the need for further investigation of how women informally learn about birth before attending formal childbirth education classes. Because the concept of formalized learning is so well documented in the nursing literature, few new studies have emerged and none of those has uncovered the role of informal learning. Therefore, informal learning as pre-existing knowledge about childbirth is the major focus of this study

The legacy of communication by women to women of their wisdom of the natural, normal process of labor and birth has now been assumed by formal childbirth classes. Childbirth educators have an ethical obligation to present a complete and accurate foundation to enhance a woman's confidence in her own inherent knowledge base. This study will explore women's

perceptions of their knowing in childbirth. It is this knowing that the current legacy of childbirth education must embrace in order to understand and to support expectant mothers as they negotiate a major life event.

Summary

The purpose of this study is to investigate the lived experience of expectant mother's perceptions of learning about childbirth. Within a historical perspective, I have introduced the concept of a feminist standpoint as it relates to birthing. There are four remaining chapters in this document. In Chapter II, I explore the literature as it relates to learning about birth from a variety of theoretical constructs. This qualitative research study is deeply rooted in nursing and education literature. In Chapter III, methodology is described with a rationale for the qualitative approach with a feminist standpoint. In Chapter IV, I will present the sample of participants and the study findings. In Chapter V, I will discuss the findings, the significance of the study, and recommendations for further research.

CHAPTER TWO

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Introduction

The purpose of this study is to determine first-time mothers' knowing about childbirth. The literature abounds with research related to formalized methods of childbirth education intended to physiologically and to psychologically prepare women for birth. Outcome studies to determine effectiveness began to appear in the literature as early as the 1940s (Triolo, 1987).

The review of current literature on women's experiences of learning about childbirth is mainly concerned with evaluation of formal learning environments from a descriptive design. Because of the methodology used, subjects were limited to the choices provided by the researchers. The few qualitative studies explore informal knowledge acquisition as it relates to authoritative knowledge. Categories of the review include outcomes broadly connected to formal and informal childbirth learning environments.

A Conceptual Framework: Learning about Childbirth

To formulate a foundation for the acquisition of knowledge that women possess surrounding the uniquely feminine perspective of giving birth, I rely on concepts derived from knowledge transfer from narratives, social interaction, and feminine culture. Telling stories of birth is an essential, traditional element that transcends time and culture. Through birth stories, perspective and intimate knowledge are shared. Often there is a window of opportunity to dialogue that promotes reciprocity and learning exchanges, particularly around the deeper issues

surrounding birth. Storytelling relies greatly on interpersonal communication to connect women and their shared history (Lindesmith & McWeeny, 1994).

Livo and Ruitz (1986) contend that during the narrative exchange, the learner reconstructs knowledge gleaned from the story and that this provides a powerful vicariously learned experience. Dialogue about the meaning of the exchange is an essential part of learning through storytelling. Expectant mothers' willingness to share their stories is an expression of the universal need to explain the unknown. In this way, knowledge is actively sought to lessen fear and to obtain a sense of control over childbirth (Zwelling, 2000).

Cultural and Social Contexts of Learning: Vygotsky

The work of Lev Vygotsky (1978), a Russian social psychologist, can contribute to a paradigm of learning for this study. Two of Vygotsky's assumptions can be related to social and cultural aspects of learning about childbirth from others: 1) Knowledge must have meaning for the expectant mother as learner; and 2) The expectant mother must command the tools for cognitive development that include significant others, culture, and language. This relevant exchange must occur within the context of her environment, thus making the knowledge transfer logical. The people sharing the stories have a great influence on how the expectant mother incorporates that information into her world. The intimate culture of sisterhood associated with childbirth communicates what must be learned to make sense of the experience. Birth chronicles play a significant role in this process because the dialogue and connection bring life to the learning each time the story is told. This social interaction is fundamental to the expectant mother's cognitive development.

Language and Human Interaction: Bruner

Jerome Bruner (1990) recognized the value of human interaction in learning. He

suggested that culture gives knowledge meaning through language and communication patterns of logic and narrative. All cultures possess folk knowledge. This theory of learning in its social context relates the development of narratives from folk knowledge to explain the range of common beliefs surrounding childbirth in American society. In other words, when events are cohesive, stories or narratives to explain those events are not necessary. With the history of interventions used in the name of modern medicine, it is little wonder that childbirth mythology, often demonized, is passed from one generation to the next.

Bruner describes a conflict between an inner and outer world that threatens perceived control. He minimizes the significance of purpose for the fictional in opposition to the factual story. “Stories achieve their meaning by explaining deviations from the norm” (p. 47). Stories explain the unexplainable in human action and human purpose. While emphasizing the norms of society, stories provide a basis for rhetoric with confrontation. This confrontation encourages the teller and listener to process the information as sense and personal relevance is individually determined. Stories have the power to remove chaos from the world and provide an environment of sympathetic memory. Each time a birth story is shared its characters and plot are either silenced or escalated.

Hermeneutic Phenomenology: van Manen

Van Manen (1990) contends that the scientist comes to the investigation with a prior knowledge, in this case human science. The better method for investigations is describing, interpreting, and self-reflection. The goal of human science is to illuminate the meaning underlying the human experience and to understand what that lived experience entails.

Phenomenology describes how one orients to the lived experience, hermeneutics describes how one interprets the “texts” of life, and semiotics is used here to develop a

practical writing or linguistic approach to the method of phenomenology and hermeneutics (p. 4).

With philosophical roots, hermeneutic phenomenology concerns understanding people in their daily lives, viewing that life experience as a whole. Phenomenology is the examination of the lived experience, the lifeworld. This methodology is a retrospective attempt to discover the underpinnings of the lived experience in question. In striving to mindfully express the meaning underlying an experience with depth and richness, phenomenology is existential in nature. Unlike other research, there is no result or conclusion in phenomenology. The connection to the results cannot be teased apart without losing meaning (van Manen, 1990).

In hermeneutical phenomenology, complete interpretive images of the human lived experience are attempted. These interpretive images center on the lifeworlds, lived space, lived time, lived body, and lived human relation. The researcher understands that complete distillation is impossible and that full descriptions are not viable, yet the phenomenologist attends to this process with strength of force in order to uncover hidden meanings in daily living. This description however incomplete should resonate with the sense of the lived world. Inherent in this reciprocity, is the process of validation. In van Manen's words (p 27) "a good phenomenological description is collected by lived experience and recollects lived experience—is validated by lived experience and it validates lived experience." Thus, phenomenology is the use of language and mindfulness to meaningfully describe a specific aspect of lived experience (van Manen, 1990).

Woman-to-Woman Legacy: Davis-Floyd

Robbie Davis-Floyd (1992), an anthropologist, interviewed more than 100 expectant women and mothers and their health care providers to learn about the impact of American birth

rituals. Davis-Floyd described a pregnancy/childbirth rite of passage as a phenomenon known as “transformation in the peer domain.”(p. 34). It is a unique bond shared by those who pass through the process together. First time mothers investigate a means to cope with their developmental crisis. It is a common occurrence that the sisterhood chooses to discuss pregnancy, birth, and children, despite who is present or what is taking place. Such engagement in serious, purposeful matters serves to socialize each other into the shared culture of their pregnancies. This knowledge is passed on in story, symbol, and example. Such personal narratives especially include the trauma of the whole pregnancy experience. As the formation of mothers-to-be becomes cohesive and solidifies, these accounts become the repertoire of the group.

Because birth stories contain vast amounts of information and are grounded in real-life experience, they offset the technology-driven model of birthing as the educational ideal. Sargent and Stark (1989) confirm the significance of these exchanges within the sisterhood of friends and family. When women share their birth stories, they decide which aspects of the narrative to share. This selection process constructs a new essence of their experience; other less significant aspects of the story fade into that part of the memory that holds it hostage. Hearing another woman’s story may trigger those memories into consciousness and a mother’s birth experience is subject to reinterpretation (Davis-Floyd, 1992). When positive birth stories are shared, they convey messages of strength and power of women as birth givers, of the integrity of the birth process, of the sanctity of the family, of the beauty and delicacy of the maternal-newborn interactions. They have the potential to change the beliefs of those who become a vicarious part of the story (Davis-Floyd, 1992).

Stories of birth that mothers tell their daughters have been altered, however, by years of a

medically managed system. As a result, there is a generation of women who are bystanders in their own stories of birth. Grandmothers, the traditional keepers of the story, are often without an active voice. The medical establishment has succeeded in compartmentalizing birth from its origin, the mother. Penny Armstrong, Certified Nurse Midwife (CNM) and Sheryl Feldman (1990) believe that women today take this stance for granted. Perhaps all mothers do not know of other times when birth traditions brought forth, at the least, support, verbal instruction, caring, and nurturance thus shaping the life purpose of every woman at that point in time. With the acceptance of birth as needing intervention, these oppressed women were chemically isolated by general anesthesia and twilight sleep from their birth experiences (Armstrong & Feldman, 1990).

As birth practices have been rigidly shaped, people have strong opinions about their protocol and their subsequent meanings. Such practices are absolutes in obstetrical culture and mother and infant are in jeopardy if anything else is considered. However, giving birth is not just about having babies. It is about women's lives, women's work, and about who owns women's bodies (International Childbirth Education Association, 1986; Lamaze International, 2002; Livingston & Denny, 2002; Lothian, 2000; Ward, 1996). To this end, women have traditionally taught each other about childbirth.

Suzanne Arms (1994) believes that before the medicalization of childbirth, girls heard stories about strength and power in birthing, not about difficulty and suffering. This is a distinction from the past and the present attributable to a loss of familiarity with the birth process, the loss of community with other women, and the loss of traditional feminine wisdom.

As a culture, we have accepted and embraced medical technology. For example, many middle-class women look to technology to help them achieve pregnancy when they experience difficulty conceiving. The implication is that women should avail themselves of all the

technological advances whenever possible. This acceptance improves the medical community's ability to control the biological behavior into comparable patterns of social behavior. This translates into medical control of conception, pregnancy, labor, and birth. Should a woman not avail herself of the offerings of technology, the consequences are then her sole responsibility. The blame for less than a perfect birth rests squarely on her shoulders (Lazarus, 1997).

In the interest of avoiding disaster, the legacy of childbirth may be lost. As women forsake their inner strength and inherent wisdom in favor of the need for medical intervention, birth knowledge is nonexistent, extinct. The absence of this knowing confirms the inadequacies of the female surrounding the complexities of childbearing (Armstrong & Feldman, 1990; Stern & Bruscheiler-Stern, 1999).

Formal Childbirth Learning Environments

McCraw and Abplanalp (1982) quantitatively investigated the reasons women attend Lamaze class. They interviewed seventy-seven women having babies for the first time. Forty-three per cent of the participants cited the desire to gain information. The remaining top three reasons for motivation to attend class included decreasing anxiety (14.3%); decreasing use of medication (24.7%); and having husband present and involved (20.8%). The investigators did not discuss the implications of preexisting knowledge or assessment of the participant's inherent wisdom.

Crowe and von Baeyer's study (1989) examined variables including fear and locus of control as a predictor for a positive birth experience. Self-reported data from 30 primiparas (woman having babies for the first time) was quantitatively analyzed. Of the 21 women participating in post-delivery assessment, it was determined that those who displayed greater knowledge of childbirth and higher confidence after prenatal class reported a less painful birth

experience. The authors believed their findings supported the emphasis in prenatal education on imparting knowledge, giving confidence, and dealing with fear related to childbirth. The impact of preexisting birth knowledge is not assessed; however, the indication for additional research on informal sources of information about pregnancy and birth is cited.

Knapp (1996) investigated the relationship between childbirth satisfaction, personality characteristics, and perceived control. A significant positive correlation between perceived control and childbirth satisfaction was determined. The data showed no relationship between internal locus of control and childbirth satisfaction. Perceived control explained the greatest amount of variance in childbirth satisfaction. These outcomes are in direct opposition with current obstetrical health care that supports the view of birth as illness and controlled by the physician. Even though support from childbirth educators is cited as a logical intervention to assist a prepared mother in becoming involved more actively with her birth, the role of informal learning is not addressed.

Mackey (1990), in reporting results from her qualitative investigation of previously pregnant women's formal preparation for childbirth, found that the majority of participants (95%) who attended classes felt the information about birthing was helpful. The participants (59%) also reported feelings of confidence to handle labor. Participant's preparation also included reviewing their previous birth experience to evaluate their behaviors during birth. However, the impact of pre-existing knowledge was not measured.

To understand the interrelatedness of factors surrounding health-related, goal-oriented behaviors and the development of confidence for labor, Broussard and Weber-Breaux (1994) formulated the Childbirth Belief-Efficacy Model (CBEM). The framework was intended to be used to design, conduct, and evaluate childbirth education classes. The researchers related self-

efficacy to achievement of behaviors, vicarious experience, verbal persuasion, and motivation. In discussing Bandura's concept of vicarious experience, Broussard and Weber-Breaux cite the phenomena of women hearing horror birth stories, the prevalent cultural view, from women who have entered childbirth with high levels of fear and anxiety. The source of this anxiety and fear, however, is not described.

Lazarus (1997) interviewed women about their pregnancy and childbirth experiences and obstetricians, midwives, residents, and medical students and nurses about their views on childbirth. She determined that women have unequal access to knowledge and differing degrees of desire for such knowledge. The participants also believed that no matter what they knew, it did not empower them to negotiate the health care system. Many women did not feel comfortable questioning authoritative knowledge and control and chose to remain silent. Unfortunately, silence was often equated with satisfaction.

Bennett, Hewson, Booker, and Holliday (1985) investigated the relationships between childbirth preparation, perception of support, and birth outcomes. Their results were consistent with previous research in determining that no relationship existed between formal preparation and birth outcomes, e.g. length of labor or complications. The role of pre-existing knowledge about childbirth was not entertained.

Using an enablement theoretical framework, Stamler (1998) examined childbirth education from the stance of the participants. Seven women were interviewed three times comparing data pre and post birth. The qualitative results that supported enablement were the participants feeling prepared, knowing what to expect, practicing techniques, and a class atmosphere conducive to asking questions.

To determine effectiveness of preparation for birth instruction, Slaninka, Galbraith,

Strzelecki, and Crockoft (1996) surveyed attendees. Most participants were Caucasian, college educated, married, and having their first child (93%). A significant relationship between information and overall satisfaction with birth was shown. Another finding revealed that although coping strategies for labor were being taught, they were not being used.

Schmied, Myors, Wills, and Cooke (2002) investigated the relationship between satisfaction and antenatal education programs using mixed methodology. Descriptive statistics were used to evaluate the differences between participants in two different programs. The qualitative data came from written comments on a post birth questionnaire. Significant results included the benefits of using adult education principles and gender-specific groups as they related to women's reports of satisfaction with parenting.

To summarize the reported research, most have been descriptive in design (Bennett et al., 1985; Broussard and Weber-Breaux, 1994; Crowe & von Baeyer, 1989; Knapp, 1996; Lazarus, 1997; Mackey, 1990; McCraw & Abplanalp, 1982; Schmied et al., 2002; Slaninka, et al., 1998) and concern the impact of formal childbirth learning environments. From these investigations, a wide range of reasons for women attending class has been reported. Although the range included gaining more information, to lower anxiety, and to increase confidence, there are many participants who did not use the strategies they learned. Even more women did not have access to the formalized knowledge, so we do not have an appreciation of what formalized learning meant to those participants. What role does an expectant mother's pre-existing knowledge play as a factor in her birth experience? How can childbirth educators capture that knowledge and build on it?

Informal Learning Environments and Authoritative Knowledge

Davis-Floyd (1990) researched the American cultural impact of society on birth and

determined that childbirth has presented the American culture with eight dilemmas that must be dealt with. The dilemmas for birthing within the American society are: (1) A society conceptually grounded in technology; (2) A society with a strong need to control nature, specifically birth; (3) A society that needs to generalize the individualized experience of birth; (4) A society that needs to control the “dangers” associated with the birth process; (5) A society that needs to enculturate an infant who is essentially culture-less; (6) A society that needs to make birth appear to sanction patriarchy when it is a powerfully female occurrence; (7) A society that needs to remove sexuality from the process of birth; and (8) a society that needs to get women to accept a belief system that minimizes them. Davis-Floyd elaborates and substantiates her dilemmas with numerous examples from her qualitative investigations. She concludes that the need exists to replace the current technocratic model with one that “honors both the birth process and the female body” (p. 187).

Sargent and Bascope (1996) interviewed and observed women from three different cultures, Mayan, Jamaican, and Texan, to investigate the connections between the distribution of knowledge about birthing within the community and the use of technology in birth. Their conclusions were that authoritative knowledge varied dependent on the culture studied. For the Mayan participants, authoritative knowledge was not highly distinguishable. The sample of the Texas participants demonstrated that control of technology and authoritative knowledge were consistent. Jamaican birthing participants verified that cultural authority of medicine might persist without technological support.

VandeVusse (1999) analyzed the birth stories of fifteen women in a qualitative study. The traditional nursing educational model was challenged by the results as the birth stories implicated a wider range of essential forces in labor than originally determined. The

investigation concluded that nurses were in a profound position to effect change by supporting women to assume more control of their birth experiences. The impact of hearing and learning from other women was not identified as a source of birth knowledge.

Simkin (1991) conducted an ethnological and phenomenological study of the long-term impact of the birth experience. During the interview process, she noted, “As I watched and listened to the women, I felt they were not merely recalling, but almost reliving the experience. Nine of them wept, either from joy or remorse” (p.209). Simkin concluded that birth has the potential for long-term negative or positive impact dependent on the support the health care provider gives. Certainly, this long-term impact will influence the knowledge that women informally impart.

From their investigation of 84 couples, Sargent and Stark (1989) established the importance of listening to birth stories for expectant mothers. In contrast, formal childbirth classes were less influential than preexisting beliefs, values, and expectations. The researchers concluded (1) that previous investigations on the technocratic model of birth has hidden the significance of socialization about birth within the framework of family and friends, and (2) there is indication for additional research on informal sources of information about pregnancy and birth.

In review, the impact of authoritative knowledge on American, Mayan, and Jamaican women has been documented as to its significance in each of the respective cultures. Each study (Davis Floyd, 1990; Sargent & Bascope, 1996; Simkin, 1991; VandeVusse, 1999) acknowledged the potential of role played by health care providers in aiding women in viewing their birth experience as a positive one. Sargent and Stark’s (1989) investigation called for further study of the importance of how women are socialized about birth by family and friends. Understanding

how and what American women learn about birthing and their perceived role within that context is critical to implementing an effective childbirth education program.

Summary

Although the importance of formalized learning about birthing has been validated (Hanson, et al., 2001; Simkin, 1991, 1992; VandeVusse, 1999), many of these studies have omitted investigating the impact of pre-existing knowledge. What influences women to seek informal information, to whom do they turn, and what is the lived experience of obtaining that knowledge, that wisdom? Most recent childbirth education research lacks a strong theoretical base and connection to the concept and impact of the how women impart knowledge with one another on an informal base. Little is known about enabling women to embrace their inherent wisdom and to reclaim their role in the birth of their children. There is a dire need for investigation of the impact of this culturally repressed phenomenon in America.

Traditional, formalized childbirth education curricula are strongly science based and are evaluated accordingly. In an effort to teach all that must be taught, informal knowledge as a critical way of knowing is often overlooked or sacrificed for a scientific, measurable outcome. Failure to recognize the importance of informal learning is a risk for the educator and the learner. For example, Enkin (1990, p. 91) states, “Prenatal classes may or may not be the best way for women to get that information.”

William Doll (1993) further explains true knowledge: “while control and authority are important, at a deeper level the underlying concept is that precision in observation and in thought—the realm that lies beyond our personal experiences, that realm that holds true knowledge” (p. 168). Without dialogue there is no metamorphosis, no interpretation, no understanding. Narratives stimulate the learner to exchange with the storyteller the potentialities

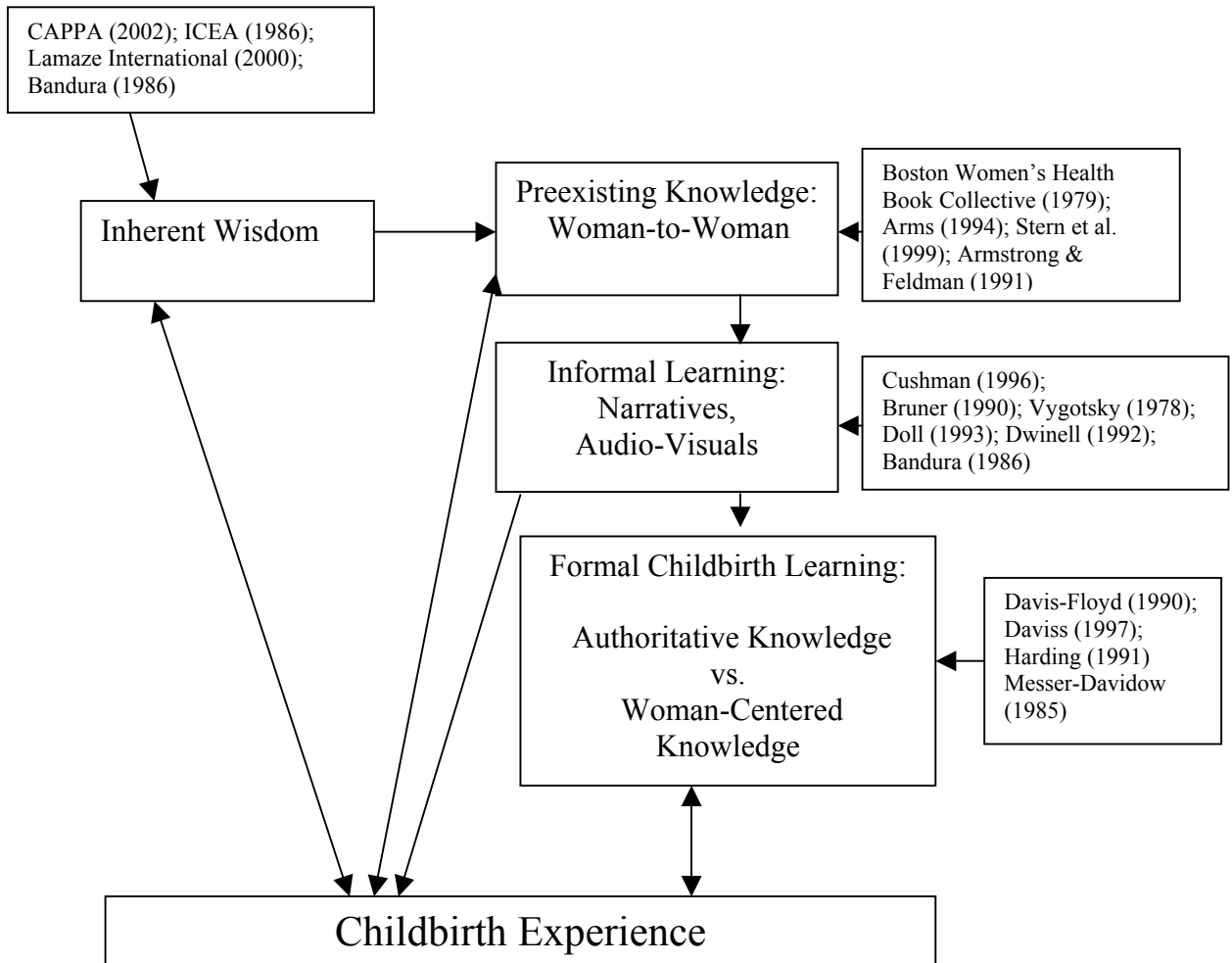
created from the discussion. The experience of dialoging enables the participants to co-mingle history, language and place in ways that change the trajectory of their experience beyond its immediate context. It is phenomena such as these that I plan to study using the following research questions: What are the experiences of learning (knowing) about birth for women? The research sub-questions to be explored are:

- What role does an expectant mother's pre-existing knowledge play in becoming a factor in her birth experience?
- How can childbirth educators capture that knowledge and build on it?
- What influences women to seek informal information, to whom do they turn, and what is the lived experience of obtaining that knowledge, that wisdom?

The methodological approaches that will be used to address these questions will be discussed in the following chapter.

In addition to the research problem, and research questions, a concept map, as shown in Figure I, was developed to portray the pattern of thinking that guides the study (Creswell, 1998).

Figure 1. Knowing in Childbirth



CHAPTER THREE

METHODOLOGY

Introduction

Phenomenological methodology was used in the investigation to better understand the issues surrounding expectant mother's lived experiences of preparing for childbirth. Preparing for childbirth is defined as any experience in which a woman acquires knowledge about the birth process. Gender is an inherent organizing tenet that shapes the exclusively feminine phenomena of childbirth and the absence of acknowledgement of the significance of feminine knowledge by traditional science.

Phenomenology is the investigation of the lived experience. The lived experience is multi-layered with meaning. Phenomenology describes rather than explains the search for such meaning (Creswell, 1998; Heidegger, 1962; Husserl, 1952; Merleau-Ponty, 1956; Moustakas, 1994; van Manen, 1990).

Human beings are distinguishable in the manner in which they are understood. Humans have emotions, purpose, values, and plans. Patton (1980) explains that understanding evolves from behavior observation and interpersonal interaction. Thus, identification with one another is a derivative of subjective states, experiences, and behavior. Despite individual variations in knowing about birth, there are identifiable commonalities that necessitate understanding.

In this chapter, I review the research methodology and the purpose of the study. The investigative process that transpired is outlined to include settings, participant selection criteria,

and data collection. The procedures used as a guide for hermeneutical analysis are briefly described. Finally, issues related to trustworthiness, authenticity, and protection of research participants are addressed.

Research Design

Phenomenology Methodology

This tradition of qualitative research is both a philosophy and a methodology grounded in the initial work of Husserl and Heidegger. While the scientists of the Descartes era held scientific process in high regard, the philosophers of the time challenged that notion and believed the scientific method to be overly mechanistic. Thus, phenomenology evolved as the preferred method to learn about life experiences (Polit, Beck, & Hungler, 2001).

Husserl is regarded by some as the "father of phenomenology in the twentieth century" (Byrne, 2001; Groenewald, 2004). The German philosopher believed that validity existed in internal experience, personal consciousness. Reality was the pure phenomena to behold and the origin of absolute data. He named his philosophical method "phenomenology", the science of pure "phenomena" (Eagleton, 1983, p. 55).

Husserl (1952), credited with the development of descriptive phenomenology, focused on uncovering what we know as humans. With a philosophical stance reflected in rich descriptions of the meaning, the essence of the human experience unfolded. Husserl contended that bracketing of one's preconceived ideas must occur to objectively investigate the experience. Such bracketing separated the researcher's personal experiences from the phenomena at hand (Byrne, 2001; Polit, Beck, & Hungler, 2001).

Heidegger (1962), a junior colleague of Husserl, reconceptualized many descriptive phenomenological perspectives. He proposed that humans derived meaning from multiple,

interwoven experiences: being human, life experiences, background, and the current environment. He thought it impossible for the researcher to bracket her assumptions about the phenomena under investigation; however, authentic reflection would serve to bring the researcher's assumptions into awareness (Byrne, 2001; Hammersley, 2000). The essence of phenomenology for Heidegger was in the interpretation of the lived experience, sometimes referred to as hermeneutics (Moules, 2002).

Reality and truth evolve from the lived experience. Phenomenology involves revisiting a specific experience to obtain descriptions that form the foundation for an analysis that elucidates the fundamental nature of the experience. The human scientist determines the infant structure of an experience by analyzing the original description of the experience. The purpose of phenomenology is to reveal what a particular experience means for those persons who have had the experience and to describe it in full (Groenewald, 2004; Husserl, 1952).

Martin as cited in Sadala and Adorno (2002) and van Manen (2000) refer to phenomenology as a method of human science study, a deeply thoughtful inquiry into human meaning. The very essence of phenomenology explores and examines a variety of sources of meaning from the people involved. Such research attempts to expose the meaning attributed to everyday life experiences rather than explain them (Welman & Kruger, 1999).

Using a philosophical stance, all components of knowledge conform to experience. Knowledge is embedded in everyday life. Such personal knowing is located within the subjective self. In phenomenological investigation, the researcher does not make suppositions, but views the area of study with fresh eyes, develops a question to steer the study, and develops findings as impetus for further investigation. Moustakas (1994) further explains, "Phenomena are the building blocks of human science and the basis for all knowledge" (p. 26).

A relationship always exists between external perception of natural objects and internal perceptions, memories, and judgments. Perception is the primary source of knowledge in phenomenology. Intentions coupled with sensation generate the perception (Moustakas, 1994).

Often described as a philosophy, methodology, and a method, phenomenology is a good fit because of its application to the experience of acquiring and contributing to knowledge (Byrne, 2001). Inherent in this tradition of qualitative inquiry is a rich understanding, an intimate knowing of, a specific life experience, learning about childbirth. Moustakas describes the role of the learner.

As a learner, to know initially what something is and means, I listen to my inner dialogue, purified as much as possible from other voices, opinions, judgments and values. This is a challenging task because we are too often taught the reverse in our homes, schools, and society. We are expected to tend to and repeat what other people think, believe, and say regarding what is true. (Moustakas, 1994, p. 62).

Phenomenological descriptions, expressions of a participant's conscious experience, begin with data collection from interviews and observations (Cohen, Kahn, & Steeves, 2000; Sadala & Adorno, 2002). Such interviews and follow-up interviews, as needed, are usually long, casual, and reciprocal, and they employ open communication. Although method should not be imposed on phenomenology, a list of questions may be used to prompt the researcher, especially the novice researcher. However, these questions may be omitted or revised as the participant shares her lived experience. Data organization and analysis sets the stage for the development of each textural and structural account, composite descriptions, and synthesis of meanings. (Groenewald, 2004; Moustakas, 1994).

Hermeneutics

Hermeneutics, the textual interpretation of phenomenology, was used to discover the meaning within the narrative. Philosophers who embrace phenomenology posit that knowing and understanding are entrenched in the totality of acts from daily living. Truth, meaning, and knowledge evolve from life experiences. (Byrne, 2001). Emphasis is on understanding rather than explaining. As a research strategy, phenomenology is clearly linked to the research question as it mirrors a participant's conscious experience (Cohen, et al., 2000; Sadala & Adorno, 2002). Hermeneutics is used to decipher the meanings attributed to the expectant mothers' experience of learning about childbirth. The goal of the phenomenological study is understanding through the examination of the lived experience. Meanings associated with the lived experience are found in the written word (Byrne, 2001; Munhall, 2001). As the researcher reads the transcribed text, the analysis process is initiated, keeping in mind that the narrative text is exploratory and time-limited.

Hermeneutics as delineated in phases by Lenonard (1994), include the initial, broad examination to achieve four objectives: to identify a stream of investigation from themes and the theoretical background; to develop a plan of analysis and criteria for coding; to code the interviews; and to identify basic groupings that lay the foundation for the research findings.

Narrative analysis of human action gives meaning in that example by examining that person within the context of her environment thus confining the meaning of the experience. Now, everything about the specific situation and the participant's responses to it are coded, thus encapsulating the meaning within the lived experience (Munhall, 2001).

In the third and final phase of hermeneutics, analysis moves to understand what the example portrays and why it is an exemplar. Such cases are sometimes referred to as "markers"

(Benner, 1985, p. 10) by which other, less obvious, but similar cases may be recognized. This case or paradigm functions to give understanding to a person's actions and interpretations that arise from her situational experience (Munhall, 2001). Another consideration of hermeneutics is offered by van Manen (1990). He describes phenomenology as how one orients to the lived experience while hermeneutics describes how one interprets the narratives of life.

Feminist Knowing

The study of knowledge, its acquisition, how one comes to the realization that one possesses knowledge is epistemology. Feminist epistemology emerged from research within such disciplines as sociology, psychology, and political science. The research from these disciplines has begun to delineate what comprises "feminist knowledge," what is implied by women's ways of knowing, and research from women's lives (Durna, 1991; Johnson, 1995).

Alcoff and Potter (1993) contend that the term "feminist epistemology" is a means of summarizing and thereby integrating women's knowledge and experiences. Multiplicity, in the postmodern sense, is a focus of feminist research. A feminist researcher must examine manifold truths in the oppressed existence of women (Ardovini-Brooker, 2002).

Using a feminist analysis, as identified by Harding (1986), three specifics are addressed. Women's experiences are rich sources for investigation. Uncovering the variations in how women learn about childbirth could alter the current thinking in childbirth preparation. Using a feminist perspective and a phenomenological tradition, meanings uncovered in those specific life experiences should enhance one's understanding of learning in childbirth.

Harding (1987) also recommends that the feminist researcher explore experiences that facilitate a better understanding of women as opposed to previous methodologies that either stereotyped women or excluded them. The last precept held by Harding (1987) is that the

feminist researcher position herself within the same playing field as her participants (who are often viewed as co-researchers). This also means that the researcher “is an active presence, an agent in research, and she constructs what is actually a viewpoint, a point of view that is both a construction or version and is consequently and necessarily partial in its understandings” (Stanley & Wise, 1993, p 6). This process mandates that all aspects of the researcher that in any way may relate to the experience under investigation be open for scrutiny. Ardovini-Brooker (2002) cautions that in such a research endeavor, “We must not assume the generalizability of our knowledge and experiences” (p. 2).

Harding (1991) further describes the complex process of knowing in relation to the invisibility of “women’s work.” While knowledge is achieved even as a woman interacts with an oppressor, the process is indirect as it seeps from the interaction. Harding contends that feminist politics embraces feminist research in order to see beneath obvious limitations. The meaning and importance women give to their work influences their knowing. Because men do not give birth, there is the distinction of giving birth as a clear line of demarcation and merit for many women.

Jayarathne (1983) suggests that most social science research has been used to uphold sexist and elitist values with little consideration given to exploring issues that are important to women. Feminists contend that researchers must become more involved and concerned about the people they study; more involved than most methods of quantitative research permit. Objective qualitative research does not mandate detachment and disinterest. Sound methodology safeguards against bias. The most effective way to initiate change within a sexist structure is to utilize qualitative investigation informed by feminist perspectives. A feminist approach increases awareness of relationships of power (Pugh, 1990).

Using a feminist approach, I have appreciation for knowledge as power. In addition,

much of a woman's knowledge is hidden, not valued, not even recognized. If knowledge is evidenced through conversation, as some scholars would have us to believe, then women's voices must be heard in the dialogues from which knowledge is formed and communicated (Boxer, 1998).

Oakley (1999) advises that when a researcher using a feminist framework interviews women, she must be mindful that the researcher is the vehicle for communicating the voice of women from an extremely intimate work of being female in a male-dominated society. Women are affected by the interview process. In researching women's transition to motherhood, Oakley cites the impact of the interview process on her participants: reflecting on their experiences, lowering anxiety, and verbalizing feelings. She explains further the positive impact of interchange that occurs during the interview process, "personal involvement is more than dangerous bias – it is the condition under which people come to know each other and to admit others into their lives" (p. 58).

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My investigation of women's experiences of learning about giving birth included methodology consistent with the tenets of hermeneutic phenomenology. This tradition is applicable to uncovering the lived experiences of expectant mothers. A feminist perspective in addition to the hermeneutical process influenced the interview dialogue. The interviews were transcribed into narrative, descriptive texts from each participant of her lived experience of

learning about childbirth in order to gain a comprehensive understanding. These data were obtained from two, in-depth interviews conducted within a six-to-sixteen-week period for each of nine expectant mothers who were having babies for the first time. Every effort was made to maintain the level of authenticity, intensity, and richness consistent with real life experience (Merleau-Ponty, 1962).

The narrations were safeguarded to ensure that the intricate details of speech, symbols, metaphors, and multiple meanings of the spoken word within a cultural context were included. The multifaceted layers of knowing inherent in phenomenology and interpreting hermeneutics were uncovered from the interviews with participants. These narratives were thought to have the potential to reveal the nuances that existed between personal knowing and authoritative knowing. My hope was that by listening to women share their understanding, an essential to childbirth education, I and eventually other childbirth educators would hear the lived experience and validate the worth in that unique experience (Anderson, 1998).

My Standpoint as it Relates to the Study

The study of phenomenology requires that the phenomenologist be aware of her own lived experiences. It is from those experiences that meaning is formed and understanding of the common experience unfolds (van Manen, 1990). My own experiential account of coming to have knowledge about childbirth most likely has stronger roots in feminist ownership than as a biological process. Growing up Southern, middle-class, white, female, the youngest of three children, in a traditional, mildly dysfunctional family had its limitations. Somewhere along the way, I learned that reading enriched my understanding. Self-learning had its own rewards; nothing was off limits to me.

I remember hearing very little about childbirth. A close family friend of my mother's was pregnant. I simply remember seeing pictures of a woman before baby and after. What comes to mind is riding in the back seat of our car and listening to my mother and her friend talk about a certain woman who lost a baby. I remember being terrified at that thought---that meant that my mother could lose me! I would always ask my mother about it and she would quiet me by saying we would discuss it later. I learned not to bring it up again. At one point, I must have been about six; I remember finding my brother's baby book in her drawer. I recognized my mother's handwriting and photographs of my oldest brother as a baby. I was fascinated and tried to duplicate the photo demonstrations with my own dolls.

Whenever I begged my mother, she would tell the story of my birth. She made it sound very exciting, just getting to the hospital in time with my brothers and the dog in the car as well as my father. Barriers were my own inability to ask comprehensive questions of the person who had the best answers. I do not remember reading any books on the subject, until finding a book on human sexuality when I was nineteen. After all, nice girls did not need to know about such things.

Being a freshman in college was liberating. There were organized protests of every imaginable sort so that even the most conservative could participate. Clearly, learning that was more interesting was occurring outside the classroom! Nursing education was oppressing. I challenged my instructors at every conventional point. From nursing courses came an understanding of how the body functioned. This knowledge was liberating, especially when most of my friends did not have this information. Knowledge, formalized and experiential, was empowering and having it was better than not having it. I felt wise beyond my years and certainly more informed than my friends did.

Nursing school provided plenty of new knowledge related to women's health and childbirth. Taking care of women giving birth is where I learned the most, especially about what women did not know and for what they were or were not willing to take responsibility.

As for my own pregnancy, I loved every minute of it. It was a wonderfully introspective and powerful time. I was very comfortable with the medical model of delivery and it provided the familiar background for my first child's birth. I expected interventions and I got them. My husband Steve and I had gone to Lamaze classes. They provided a wonderful bonding experience for us. Steve was a great coach and I came away feeling very grateful that he was by my side. And more important, he was actively involved in bringing our daughter, Jennifer, into this world.

When Jennifer was three months old, I became a certified childbirth educator. Two years and 9 months later, our second daughter was born. Kelley was born in a birthing room with minimal intervention. Again, with the support of Steve, Kelley's birth was a positive experience.

I did not care how my knowledge was going to be received by my health care providers. I went into that experience with the feeling toward the other nurses "go ahead, try to show me something I do not already know." I felt I would have to defend my birth preferences and knew that much of their motivation for care would be based on convenience for them. I had been in their shoes, but I was different now. I do not think I really valued their knowledge.

I took an active role with the births of both my children. Moving to stay comfortable and ignoring the ritualistic chants of the nurses, "Don't do that, you might hurt the baby. You don't want to hurt the baby, do you?" I do believe that women have an intuitive sense that guides them. However, this voice of knowing may be overshadowed by their insecurities or the passiveness that takes place for women during labor. Something has to happen that makes them feel that their knowledge is valued and that does not happen often enough.

My first birth experience with a woman who was “self-taught” was exhilarating. She changed my nursing care perspective from “hospital routine” to woman-centered. After introduction, Janet told me she was going to have a Lamaze delivery. I nodded as I recalled my knowledge of Lamaze to be a matching question from an obscure test. She assured me that she would need nothing for pain because breathing techniques, her focal point of a hot air balloon poster, and relaxation would be all that she would need. After all, she had read the book; what more could she need? Oh, there would be one more thing- a coach. Her husband was offshore working and she needed me to fill in for him. It was thrilling! When labor was over, I wheeled her back to delivery. Legs in stirrups, sterile drapes in place, everything looked the same as usual, except for one major thing: we had a mother who was awake, aware, and talking coherently. When her baby was born, Janet reached out for him. I had never seen that before. I immediately gave her the baby. As he lay on her chest, I completed the assessment. The baby was fine; Mother Janet was fine. The physician was angry because Janet had not been medicated. He was certain she had suffered. The nursery nurse was upset because Janet did not want to give her the baby. This birth was safe, joyous, and powerful. From that point onward, practicing nursing by the technocratic model became increasingly harder to do.

Although I was a willing participant in Janet’s birth experience, I did not suggest any of these interventions to her. I co-existed during this experience of her birth. van Manen (1990) professes that self-evidence evolves from life experience. Participating in Janet’s birth experience made a fundamental difference for me as her nurse and for the woman I was at that point in time.

Participants

With the goal of achieving a diverse picture of women’s knowledge in childbirth, an

initial goal of eight participants was targeted. However, data saturation and redundancy was not reached with eight participants and another expectant mother was included which produced saturation. Hermeneutic inquiry is validated by the fullness of examination of the topic and depth and breadth to which the analysis expands understanding, not by numbers of participants (Moules, 2002). Two certified nurse midwives, one serving those women who qualify for public assistance or private pay and the other who serves those with private health insurance and those with public assistance were to serve as gatekeepers for referrals of women having babies for the first time (primigravida) and who have recently had their pregnancies confirmed.

Setting and Sampling

The setting of the study is a metropolitan area in the West South region of the United States. The culture of the identified area is cosmopolitan in nature. To increase the range of experiences and demographics, I interviewed referred clients from two midwifery practices, as the majority of women in the area utilize physicians as health care providers, Because the phenomenological experience mandates the method and participants, my sampling method was both purposive and one of non-probability (Cohen et al., 2000; Groenewald, 2004; Hycner, 1999)

Perhaps the uniquely female nature of experience would contribute to the feminist standpoint by including many perspectives of the lived experience and determining the differences and similarities of meaning of these events as they related to women's lives (Harding, 1991). I was ever mindful of the need to give voice to those who needed to be heard as a major point in phenomenological research (Cohen et al., 2000).

Data Gathering

Data gathering was through open-ended, semi-structured, in depth interviewing in a

mutually acceptable location, for example, the participant's home or clinic site. This framework for data gathering permitted focused, conversational, open communication. Some of the main benefits of semi-structured interviewing include (1) a less intrusive nature that facilitated discussion of sensitive issues; and (2) learning the reasons behind the answers given (Creswell, 1998).

Qualitative interviewing routinely uncovers hidden elements (Weiss, 1994). Critical to the process is remaining open to the expressed narratives. I contacted women who were pregnant for the first time and to date were having medically uncomplicated pregnancies. All participants were mailed an introductory letter and one copy of the approved institutional consent form. Inclusion criteria were: (1) adult (over 18 years of age), (2) English speaking and (3) primiparous (having first baby), (4) pregnancy to date without complications, and (5) willing to participate. Telephone calls or emails were made to each woman to clarify the purpose of the study and to schedule an interview. Meetings were scheduled at mutually agreeable times and places. Interview settings included most often participant's homes, offices, and clinic. At the beginning of the first interview, two copies of consent form were reviewed and signed. The expectant mother kept one and I kept the other. All women gave consent by signing.

Although I had a list of questions as a guide, an open, exploratory approach was to be used for interviewing. Nine women were interviewed which provided redundancy. I expressed interest in hearing how the expectant mother was learning about giving birth. Each participant was assured that there were no "right or wrong" answers. I wanted the narrative to unfold without restriction of chronology. Interviews were audiotaped with participant permission. Each participant selected the pseudonym of her choice and that name along with the date was used to label each audiocassette. Brief notes were taken and my responses to the interview (notes on

conversation and physical setting) were written or tape-recorded after the interview. All participants agreed to be audiotaped.

The transcripts of the participant perceptions, journals, and demographic data formed the data for the study. The initial interviews were anticipated to last a minimum of one hour with each participant. At the end of the initial interview, demographic information was collected. After six weeks, I planned to conduct the second interviews in person or by phone for a minimum of thirty minutes. If participants agreed to keep journals during the interview interval, then they were retrieved at this point, photocopied, and returned by mail. Only those points in the journals that were relevant to the research questions were transcribed for data analysis. I transcribed each interview verbatim and copies were mailed to participants to review for accuracy, revision, or deletion. The only changes made in the transcripts were those with identifying information, which would compromise anonymity, or those requested by the participants. Although field notes were recorded after each interview, they were not treated as investigative data. To maintain an open perspective, it was important to record what I saw, heard, experienced, and thought (Miles & Huberman, 1994).

The goal of the interviews was to reveal the experience of learning about birth for first time mothers. My intent was to interview each participant at least two times with a minimum of a month between interviews. Ideally, the first interview would have occurred early in the first trimester and the second toward the end of the second trimester. However, most participants came into the study during their second and third trimesters. Due to participant preferences, such as holidays and giving birth, the second interview did not always take place six weeks from the first. Two of the second interviews were via phone for participants who had given birth. This time span of data collection was intended to reveal a greater richness of wisdom/knowledge the

closer to delivery the participant came. The study protocol was reviewed and approved by All-University Committee on the Use of Human Subject, University of New Orleans.

Data Treatment

Reducing Bias

All nine interviews were audiotape recorded and transcribed after each interview. Data that did not relate were isolated. Stories that gave strong patterns of meaning from the related data were read and reread (Benner, 1994). The following steps as suggested by Creswell (1998) were taken. Each interview transcript was read multiple times for understanding of meaning (Lawrence-Lightfoot & Davis, 1997) to identify groupings of categories. Care was taken to avoid separating the connection to the original narrative. Theme clusters were then formed with discrepancies within and across data noted to provide a comprehensive description of the experience.

As recommended by Cohen et al. (2000), Spall (1998), and Spillet (2004), peer debriefing and member checking were used to open up the inquiry process. With my initial peer debriefer, the narratives were independently read and reread. Coding comments were made in the margins. I then met with my peer debriefer to review each transcript and to come to an agreement on category interpretation. Categories were then revised and compared to the narrative. The development of themes occurred at this point. Patterns of meaning that common to all the participants and those that were unique were identified as such in order to determine if a relationship existed among the themes to provide textural (what was experienced) and structural (how it was experienced) descriptions. Each participant received a copy of the interview transcripts for revision. Two participants did make revisions. An audit trail of this process was audio recorded in addition to notes made directly on the transcripts. A second peer debriefer

reviewed the theme development and organization. A summary of the study findings will be shared with those interested participants.

Ethical Considerations

Conceivably all social inquiry is connected to ethical consideration. Informed consent was obtained as both an initial and on-going component of the negotiated research relationship. Many issues surround exposing normally hidden thoughts and feelings during an interview. The interviewer must remain faithful, non-judgmental, respectful of the commitment to confidentiality, and maintain the researcher role. Trust, compassion, and empathy permeate the research relationship (Munhall, 2001). Because of the intensely personal nature of some of the interviews, I did leave many interactions with feelings of protectiveness toward the participants. These feelings certainly influenced the data analysis process. Some of the participants stated that reasons for their participation included altruism and needing someone to talk with. None of these relationships has continued.

Rigor and Trustworthiness

Rigor and trustworthiness constitute validity for qualitative research. A component of trustworthiness is believability. The qualitative researcher must substantiate attempts to maintain credibility, transferability, and dependability (Beck, 1994). Maxwell (1996) delineates types of validity concerns in qualitative research in the following ways: description, interpretation, and theory. Researcher bias and reactivity are threats to validity.

To avoid compromising description validity, relating what I saw and heard, I audiotaped the interviews and field notes to offset this issue. Such verbatim accounts allow accurate analysis and conclusions. To maintain the integrity of the interpretation process, I actively listened to understand the meanings the expectant mothers assigned to their words and behaviors. I was

careful to record and reveal the experiences of the participants by using open-ended questions that encouraged the illumination of the participant's lived experience. Member checks were used when participants reviewed their transcripts for accuracy to maintain credibility and rigor. Paying attention to conflicting data was challenging. I attempted to devise comprehensive explanations by using current literature.

Researcher reflexivity was addressed in my autobiography and the study limitations specifically, my biases. To aid in the reflexive stance, these reflective field notes included my feelings, thoughts, and reactions prior, during, and after the interviews. In examining the researcher-participant relationship, my personal influence on the participants could not be eliminated, but I was certainly aware that my multiple roles as a woman/childbirth educator/nurse/researcher would influence the interview process. To offset this power differential, the participants chose the time and place for the interviews. There are no assurances of validity, however the following strategies were used to enhance the credibility of the conclusions (Maxwell, 1996; Miles & Huberman, 1994)) Multiple sources of data were used to address content validity (Hycner, 1999; Munhall, 2001). These sources included two interviews, journal entries from five of the participants, and field notes. Peer debriefers were used for confirmation of analysis after 1) completion of the initial analysis; 2) after data from the initial analysis were categorized; and 3) when all categories and themes were developed.

Delimitations

My limited expertise and time constraint were real threats to the findings of this study. Although the reports of birth experience knowledge were expected to be diverse, the self-selective sample was small. However informative, I did not intend the findings to be applied to any other group.

Summary

My experience in assisting women prepare for childbirth has stimulated my interest in how women discover their own personal wisdom surrounding childbirth. This investigation may contribute to the feminist literature and to childbirth education beliefs and philosophy. This research may enable women, health care providers, and educators to appreciate the pre-existing knowledge that women who seek additional perinatal education or as partial rationale as to why other women do not seek formal perinatal learning.

CHAPTER FOUR

PRESENTATION OF DATA

Introduction

The primary research question, what are the experiences of knowing about birth for expectant mothers, directed the process of data collection including the implementation of the phenomenological tradition for participant demographic information, and characteristics of the expectant mothers participating in the study presented in this chapter. I then present findings from the hermeneutic process of seeking to uncover meanings as related to the participant's experience of learning about childbirth. The themes resulting from this phenomenological process are supported by the rich descriptions of the expectant mother's experience and serve to sustain the analysis of findings.

The secondary research questions that I intended to explore were:

- What role does an expectant mother's pre-existing knowledge play in becoming a factor in her birth experience?
- How can childbirth educators capture that knowledge and build on it?
- What influences women to seek informal information, to whom do they turn, and what is the lived experience of obtaining that knowledge, that wisdom?

The responses to the first two specific sub-research questions were difficult to tease apart from the data. I found it tedious to attempt to determine the role of pre-existing knowledge among the participants especially when significant others did not seem to be forthcoming with

information as the participants were growing up. That being said, if that knowledge is difficult to confine, it would also seem difficult to build upon.

This study consisted of four types of data: interview data, field notes, journals, and demographic data. With the exception of field notes, all data were reviewed and analyzed to reveal crucial characteristics and relationships (Coffey & Atkinson, 1996). A warning against the use of the term analysis in phenomenological research exists because of inherent risky implications (Groenewald, 2004; Hycner, 1999). If the researcher breaks down the interview narrative, as is intended in the word “analysis,” there is the danger of losing the total phenomena that were intended to be captured. The goal then regarding analysis was to examine, while maintaining the whole.

Description of Participants

A phenomenological methodology, especially one with a feminist perspective, demands an expositional examination of life. With that in mind, I offer descriptions of the first time expectant mothers.

Shantell and I met face-to-face in the clinic of her midwife for our first interview. With no outward signs of pregnancy, Shantell indicated she was sixteen weeks pregnant. One of six children, Shantell is 18 years old, African American, and a high school student who lives in the inner city with siblings and her mother. Our second interview took place at the clinic as well.

Anna, an only child, is a 20-year old African-American college sophomore who grew up in the northern part of the United States in a closely-knit family. She is not showing any visible signs of her 16-week pregnancy. We also met in the health clinic. She expressed admiration for her grandparents who are a strong source of support for her. The father of her child lives in the same town as her grandparents so they have limited contact. Anna currently lives with two

female roommates in an apartment in a suburban area. However, Anna feels isolated from them and her child's father, as they are not available to her for support when needed. By the time of our second interview, in the clinic, four weeks later, Anna had changed plans. She has already started Lamaze childbirth preparation classes and intended to move to her mother's home in a southeastern state to have the baby. There she will intercept the father of her child as well. She was full of excitement because everything that had been planned had now been changed and she delegated finding healthcare to her mother, who, she relayed, was delighted with this new mission.

Kayla is Euro-American, 19 years old, and 20 weeks pregnant. We met in her home in a rural community outside the greater metropolitan area. She has lived here all of her life with her mother, grandmother, three younger cousins, one bird, and four dogs. We interviewed in her kitchen while her grandmother watched television nearby. Kayla dropped out of high school and intends to get her GED. During our interview she emphasized many times that she did not think she could get pregnant because of her "female" problems and she had only recently started having intimate sexual relations. This pregnancy is unplanned and the father of her baby is undetermined. She plans to have DNA testing after the birth of her child to rule out one of two possibilities. She has had periodic contact with both young men in her life during the pregnancy.

Sophie is 27 years old and has one younger brother. At her 33rd week of pregnancy, we met in her home for our first interview. She is Euro-American, married, and recently left her executive position in the hotel industry. Sophie has completed graduate school. After having meningitis in college, Sophie takes anti-seizure medication that could affect her baby's outcome. This medication has necessitated careful monitoring with ultrasound of fetal development.

During our first interview, Sophie's husband remained in the next room. Sophie's daughter was born three weeks early and healthy. Our second interview also took place in her home.

Lilly, age 30, who describes herself as having a German and French heritage, has completed her master's degree. She grew up in a family with four older brothers and her mother is a nurse who works in labor and delivery at the hospital where she plans to have her baby. Lilly has been married less than two years. She was instrumental in getting her family and friends to compete in the Boston Marathon. This will be the first year in many that she will not compete. Lilly left her pharmaceutical sales job soon after her pregnancy was confirmed. Both interviews took place at the kitchen counter of her new home. At the time of our first interview, Lilly was 19 weeks pregnant. Our second interview was when Lilly was 26 weeks pregnant.

Olivia is a 28-year-old graduate student. She grew up along the Atlantic coast in a family with one older stepsister and one younger brother. Olivia describes her ethnicity as Irish-German. She was 28 weeks pregnant at the time of our first interview, which took place in an office at the university. She lives with her husband and two dogs. Our second interview via telephone took place nine days after the induced birth of her daughter. Olivia has made a decision to take a leave of absence from her graduate studies.

Harper, an only child, is a 35-year-old, self-described French-Irish woman. She has completed her undergraduate degree in women's studies. She lives with her life partner and two dogs in an apartment behind her mother's home. Harper left her position in the job market some time ago to facilitate the artificial insemination process. She was 30 weeks pregnant at the time of our first interview, which took place in her home. She was open and animated during our interviews. Our second interview was during her 39th week of pregnancy. Harper delivered her son via c-section two weeks later.

Jenn was 33 weeks pregnant at the time of the first interview that took place in my office. She is a graduate student there studying in another curriculum. She is the firstborn in her family and has one younger sister. Jenn grew up in the Rocky Mountain region of the United States and came to this region for a career opportunity, but decided to start graduate school instead. She learned she was pregnant after the move. The father of her baby was able to find a job here and moved several months later to join her. Our second interview was again in my office, three weeks after Jenn had been induced for the birth of her daughter, at the start of the new semester.

Erin was 33 weeks pregnant at the time of our first interview at her home. She is a chemical engineer with a Bachelor of Science degree who delivered her daughter four weeks before her due date. Erin is 36 years old and grew up on the Central Eastern coast of the United States. Erin is the oldest of three daughters, and she describes her ethnic background as Caucasian. During our first interview, her husband remained in the room but did not verbally contribute. Our second interview was over the phone, two weeks after her baby was born.

Demographics

From the recruitment process, nine first-time expectant mothers volunteered to participate in the study. The ages of the participants ranged from 18 to 36, mean = 26.7, and are shown in Table 1.

Table 1

Age Distribution of Expectant Mothers

| Age (years) Ranges | Number of Expectant Mothers |
|--------------------|-----------------------------|
| 18 - 24 | 3 |
| 25 - 31 | 4 |
| 32 - 36 | 2 |

n = 9

Although I did not directly ask about health insurance during the interview process, participants shared information that revealed this data. Four of the participants had private health insurance. Two expectant mothers were anticipating delivery with a Certified Nurse Midwife. One woman was undecided about her health care provider because she was moving to another city and one expectant mother expressed dissatisfaction with her health care provider and changed providers during the study. The remaining six had planned for an obstetrician to attend their delivery.

The highest grade of school completed ranged from 11th grade to a Master's degree. Table 2 summarizes the years of completed education for the participants. Five of the participants had arranged to attend, were attending, or had completed hospital-based prenatal or Lamaze childbirth classes. Four of the nine participants gave birth before the second interview. Two of the four women's labors were induced with synthetic oxytocin for non-medical reasons. The two remaining participants had babies that were born three and four weeks early.

Table 2

Years of Education of the Expectant Mothers

| Educational Level | Number of Expectant Mothers |
|---------------------------------------|-----------------------------|
| Grade 11 | 2 |
| College Student | 1 |
| College Graduate | 3 |
| Graduate School: 1 st year | 1 |
| Master's Degree | 2 |

n = 9

At the time of the study, four of the participants were attending school full time, four were unemployed, and one was working outside the home. At the time of the first interview, the participants were from 16 weeks to 33 weeks into their pregnancy, mean gestational age = 25.7 weeks. Table 3 summarizes this information. By the time of the second interview, four participants had given birth. All participants who delivered during the study had labor support. Four expectant mothers had their partners with them. In addition, two mothers of the participants attended the birth of their grandchildren.

Table 3

Reported Weeks Gestation at Time of First Interview

| Number of Participants | Weeks |
|------------------------|---------|
| 4 | 16 - 20 |
| 5 | 28- 33 |

n = 9

Four of the participants did not grow up in their current region of residence, the setting of the study. The ethnicity of the participants was self-described. Two participants identified their ethnic background as African American and seven described themselves as Caucasian. At the time of the interviews, four of the participants were married and living with their spouses, while two were single and living with a partner, and the remaining three were single and living in or would soon return to their parents' homes.

In summary, I chose participants by using purposive sampling. While purposive sampling is a valid style of non-probability sampling, personal reasoning and consideration of the research question were used to find participants who were pregnant for the first time, experiencing an

uncomplicated pregnancy, and willing to participate in the study (Groenewald, 2004; Welman & Kruger, 1999).

I used professional networking within the healthcare community to locate the manager of the clinic I used to obtain permission to use her site for interviews and to have the midwife refer participants. The clinic-certified nurse midwife gave me the name of another certified nurse midwife who sees private patients. Both the clinic manager and the certified nurse midwives received copies of the research proposal and copies of institutional review approval. I developed flyers briefly describing the research topic and process to be given to the clients that the nurse midwives felt met the study criteria. After dropping off fifty recruitment flyers to each midwife, only three participants indicated interest. When participants were slow to materialize, I appealed to another childbirth educator at a professional meeting for referrals. I delivered flyers for her to give to her clients. One participant was recruited via email when she was requesting information about childbirth classes. Two participants were recruited from my childbirth preparation classes. Of these two expectant mothers, one did not indicate interest until she had completed Lamaze Childbirth Education classes and her interview was scheduled at that time. The other participant had her first interview during the last week of class. Three participants evolved from the nurse midwives, three from another childbirth educator.

Findings

Being aware of van Manen's (1990) lifeworld existentials, "the lived world as experienced in everyday situations and relations," (p. 101), three patterns of knowing emerged as I read and reread the transcripts in varied order that embodied the lifeworld existentials. van Manen (1990) contends that the "four existentials of lived body, lived space, lived time, and lived relation" (p. 105) are distinguishable but not separate from each other. Three concepts:

corporeality, temporality, and relationality, from van Manen's (1990) lifeworld existentials structured the organization of the themes and are shown in Figure 2. Ever mindful that these lived experiences are not mutually exclusive, I took great caution against reducing them as such. The experiences of the expectant mothers overlapped more than they self-limited.

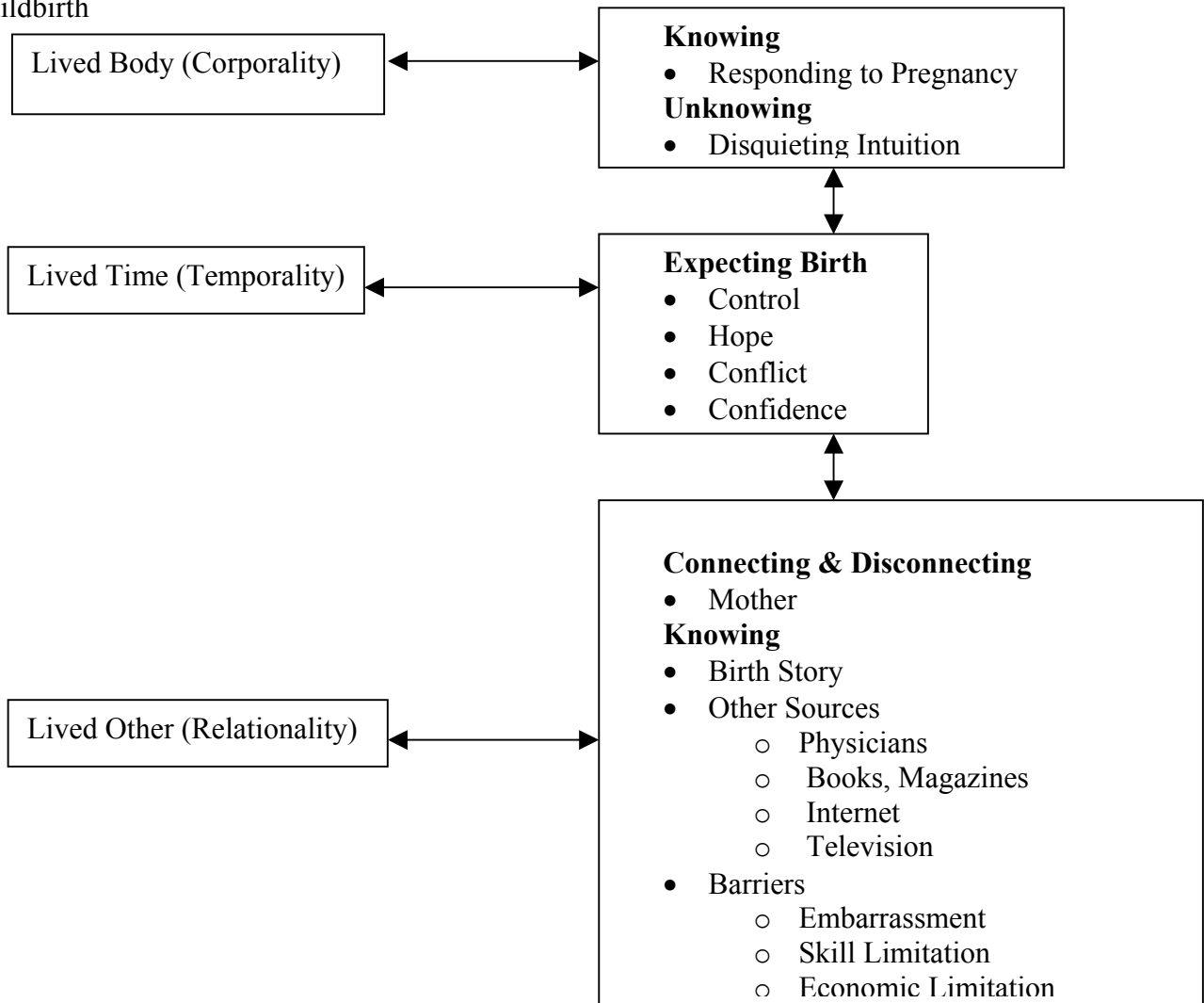
Three lifeworld existentials of van Manen (1990)--physicality, temporality, and relationality--applicable to this study are briefly addressed. It is through our physical presence (corporality) that we experience the world. A physical boundary of embodiment, permeable to some, is a knowing connection between humans. Lived time (temporality), a subjective experience, is the human materialization of a past, present, and future. Selective memories influence temporality. These memories shape our lives both cognitively and emotionally as feelings and thoughts, all of which are influential in the form of fear, aspirations, and anticipation of what is yet to be. As humans share their private domain with others, that intimacy invites relationality. Characteristics of relationality include life purpose, human meaning in existence, and acknowledgment of a higher power (van Manen, 1990). See Figure 2.

To achieve immersion, I read the data repeatedly; I organized the transcriptions according to topic, with digressions set aside, sorted and resorted for linear coding and theme development (Cohen et al., 2000).

As the expectant mothers unfolded their stories about learning about the birth process, the women shared what is like to be pregnant; what they thought their labors would be like; their relationships with their mothers, and their relationships with their health care providers. In keeping with the notion of a full textual description, I uncovered qualities that contributed to the unique experience of learning about childbirth. I used van Manen's (1990) process of "free

imaginative variation in order to verify whether a theme belongs to a phenomenon essentially” (p.107).

Figure 2. Derivations of Themes from Expectant Mothers’ Lived Experiences of Knowing in Childbirth



Each theme was considered as to its impact on the phenomenon if the theme was hypothetically omitted or changed. Further, with that supposed change, van Manen would question if the phenomenon lost its initial essence.

To bring to life their experiences of learning about giving birth, I attempted to describe in full that process by using their words in detail. Originally, I extracted over eleven themes. Many were collapsed or regrouped into the existing themes to more coherently group units of meaning together (Creswell, 1998; Moustakas, 1994). Given the phenomenon, I also noted in this process that there was significant interconnection in the theme clusters. I found it difficult to specify distinct boundaries among themes, especially as they related to control issues and maternal connectedness for the participants (DeVault, 1990).

Knowing: Responding to Pregnancy

Because the context of the investigation centers on each woman's experience of knowing as related to her pregnancy, I felt it important to turn to the expectant mother's perceptions of this gender-specific life event. The overt and covert corporality of the experience forces a woman to experience her world through her pregnancy. As the nine participants were varied, so were their descriptions of their first experience of pregnancy. Some expectant mothers focused on the liability and discomforts of pregnancy, yet overall they believed their pregnancies to be positive.

In our first interview, October 28, 2003, Lilly reported:

It has been easy. I found out that I was pregnant very early in the game and I was probably sick for two or three weeks where I did not feel really well in my 8th or 9th week. Other than that, I have felt great. My pregnancy has been a little bit easier than I expected.

During our first interview on January 6, 2004, Erin described her pregnancy by saying:

It has been good for the most part. I have had a couple of months of morning sickness - all day morning sickness. But, other than that, it has not been too bad. I am just now starting to slow down . . . Overall, it has not been that bad.

At our first interview, November 12, 2003, Harper was thirty weeks pregnant when she shared these feelings about the process of finding a sperm donor and establishing a successful pregnancy:

We are so excited. We waited so long for this baby . . . We have had the whole baby ensemble for seven years. We have been buying baby clothes for years and years. It has been a long arduous process. This is a real miracle for us.

Shantell, a high school student, described the reaction of her family, “My mama, my auntie, and my grandmother just told me stuff. They told me it was a mistake. At first, they were not okay with it. They were mad.” (Interview I, October 9, 2003).

Anna, a college sophomore, shared her experience of her mother’s response to her pregnancy (Interview I, October 9, 2003):

Lately I have talked with my mom, but not before that because she was not very happy. I have just started calling her. I have older friends who have given birth that when my mother was not coming around quickly enough, I could ask them.

Jenn, a graduate student, describes her experience as one of self-discovery (Interview I, November 24, 2003).

It varies sometimes from minute to minute as to whether or not I am enjoying it. I don’t know. I think everybody has their own experience. I started out and was very sick to the point where I lost a lot of weight because I could not eat anything. My mom had not experienced that. And anyone else that I have talked to, said [they were] a little sick, but

not like I was. Overall, it has been a good experience. I think I have learned a lot about myself. At first, I can deal with a lot more than I thought I could. I have been on my own for six and a half months. That was tough. But, it was also good just knowing that I could do it. I had already moved here and learned that I was pregnant. I found out three days before classes started. The emotional aspect is interesting. I tend to go more to the weepy sad side of things. It has just carried over. I think that is my personality. It has been extreme. Watch a commercial and I cry or being in Wal Mart and start tearing up for no apparent reason!

In our first interview (November 19, 2003), Sophie discussed many things about her pregnancy. The pregnancy had been medically uneventful; however, she has a chronic illness that necessitates her taking medication. She has had numerous ultrasound assessments to verify that the baby is healthy and growing. Sophie, who recently left an administrative position, described her pregnancy in this way:

Anticipation is the word. The best part of a trip is the anticipation, I think. This is my biggest excitement. The ultrasound is amazing. It blows us [her husband] both away. Just trying to visualize that there is something from nothing. That is the thing that we cannot get past. Just that there is something else here. The ultrasound made it real. We actually saw her and she keeps getting bigger. (Laughter) It made me cry. I did not realize I was crying. I think so many emotions. I am into the anticipation. And everything has been so perfect. I hate to say it, has been so normal so far. I don't want to say perfect! I have been kind of crazy like that about things; I would not buy anything for her until very recently. I am like that about anything. So far ahead and assuming it will all just be perfect.

Kayla has dropped out of high school to have her baby. She was the only participant to openly share that her pregnancy was unexpected; paternity is uncertain at this time (Interview I, October 13, 2003).

Sometimes it can be rough—like having a few problems. I wasn't supposed to be able to have kids. It is almost a miracle thing. It is just some days you are not happy and you just cry for no reason. Other days I am happy and just cry for no reason, and other days I am very happy. It is a joyful thing. Some days I don't really want to be pregnant. But, I want to be, because she [the baby] is an amazing thing to me. But, some days you hurt! Some days you do not sleep nights. You can sleep some nights and some night you cannot. It is weird. It is different. All of a sudden, she just kicks you. Sometimes it hurts, but it is good.

Olivia, (Interview I, October 24, 2003) married and in graduate school, shared her perspective of pregnancy:

I came into it naive. I looked at it like, won't it be great to have a nine-month vacation from my period. I guess I had a more typical male view of it, something that you can rather forget about. You can be pregnant, but it will not be central to your life. It will be something going on in the background. At the end is when it really becomes central to your life.

As a last journal entry (Journal Entry IV, no date), Olivia recorded these thoughts and feelings:

Before I became pregnant, I had very positive expectations of what pregnancy would be like. Emotionally, I believed that being pregnant would make me blissfully happy. Socially, I felt that it would mean lots of positive attention from my husband, family,

friends, and colleagues. Physically, I expected that it would involve some discomfort but that it would prevent me from having to endure menstrual cramps for nine months. I expected that I would enjoy my pregnancy and not want it to end.

From our first interview, Olivia also related her feelings of sharing the news of her pregnancy with her mother:

It was very clear to me that she expected me to complete my education and she wanted me to go on to graduate school. I was even afraid to tell her when I got pregnant because I was in my final semester of working on my master's degree, I just had to prepare myself that she was going to be so disappointed and she wasn't. She was not as enthusiastic as some. Some mothers are just baby crazy when their own children get pregnant. She was happy about it. I think she still has in the back of her mind concerns about it. Does this mean I won't finish my PhD? I try not to talk to her too much about school concerns. My mom has always been very overprotective, paranoid, if I mention things that may go wrong or things I am worried about. She tends to get very worried herself and make many suggestions about how to avoid it. So, I have really been trying to keep the academic concerns out of our conversations.

Interestingly of the nine expectant mothers, two identified their pregnancies as "miracles," one pregnancy being unexpected and the other deliberately planned. The reactions of significant others, specifically their mothers, to their pregnancy was important to many of the participants in this study, important enough to have influenced their own perception of the experience. Although some expectant mothers addressed the emotional liability and discomforts of pregnancy as bothersome, most reframed their pregnancy experience as positive, better than they were expecting.

Unknowing: Disquieting Intuition

The corporality of the lived experience of pregnancy entails internal processes as well. One example is an inner wisdom to guide a woman through birth. Many of the expectant mothers described their experience of understanding of their own intuition as being void or distrustful of it [intuition]. During our first interview at the clinic (October 9, 2003) Shantell shared, “I don’t have any right now.” At our first meeting, another participant, Lilly (October 28, 2003) was hesitant in recognizing the presence of her intuition, “I have just started to think about that. Sometimes it is a little scary. . . I do not let myself wander as deeply as I should and need to.”

Anna (Interview I, October 9, 2003) is in her first trimester and living a great distance away from her family while she attends college. She was quick to relate her sense of birth intuition as something she does not trust.

You know it is real easy—cause for now, my mom was my intuitive sense. No decision was made without my mom knowing. People who know tell me I have to think for myself. My grandmother would ask me questions—and my mother answers for me. So, it has only been for the last several months that I have been able to think on my own. But, I am not doing a very good job because I still have to call my mom and ask her what I should do. I do not have an intuitive sense just yet—really to be honest—I do not think I really have one—maybe that comes with the motherhood package. I will get it. For now, I am still someone else’s child. I cannot find it. I do not trust my own inner wisdom. I do not trust what is going on inside of me. I have to depend on someone else, if not my mother, a close friend. I do not think it is weird because it is not like anything that has happened before

where I have said, I am going to do this on my own and it turned out wrong. You are supposed to get help. How could you not do anything else?

Anna is relying on her mother for internal and external guidance at this point in her pregnancy. She needs to depend on her mother and relates that need to a personal lack of knowing. Anna believes and it makes sense to her that she must get help.

Harper (Interview I, November 11, 2003) captured her ability to tune in to her body as a coping strategy and wondered if her birth intuition could compare to her experience with chronic pain.

I have lived with chronic pain all my life. I am not going to fool myself into thinking the pain is not similar, but I have been in excruciating pain with no meds. I have done breathing techniques and movement to take my mind off it until out of sheer exhaustion I fall asleep. I have always been in tune with my body. Could any of that equate to childbirth?

Erin (Interview I, January 6, 2004) wants to stay home as long as possible to “listen to my body at that time and not have all the other distractions.” She explained her sense of birth intuition like this:

The whole process of giving birth is a natural process and your body does respond. Look at what has happened during pregnancy; look at all the changes. I would say-how do I describe my intuitive sense? Moderate . . . That is your body, there is really not a whole lot, sometimes you can do mind-over-matter but—so I do trust that I will be able to follow the contractions and give birth and that my body knows how to do that, but I also know that all the outside forces and the internal forces as far as the responses that I have . . . The interaction of the drugs, the people influencing those can affect that intuition as

well. . . I do believe that if I were stranded on a deserted island that I could give birth and follow my body signals, provided there are not any bad complications I can handle that I can do that. I do worry. In a hospital setting, I worry about all those other things the medication is going to affect that some; the people that are around me are going to affect it. They are going to affect me by giving me the directions that I need to do what I need. Erin continued to discuss the impact of the birthing environment on her sense of intuition.

Every bit of the information that is coming to me is coming to me from my body so I respond to that. But, in the hospital there are machines monitoring and beeping; numbers going up and down, there are drugs that may influence the feelings that I am getting from my body or take them away completely. There are people that may make a comment, an innocent comment, that in my mind it is going to mean something to me that may influence how I am responding. I do think once you get in a hospital all those other influences affect how you respond to what your body is telling you. That is what I think. It may be totally different.

After much concern early in her pregnancy, Olivia (Interview I, October 24, 2003) explained her perception of being in tune with her body as separate from intuition surrounding birth:

I am a big believer in patterns, and I guess I was very worried in the beginning about things going wrong, about miscarrying, birth defects, premature labor, and that sort of thing; I look for assurance by talking to my mom and by looking back over my pregnancy. Nothing went wrong with my mom's births. We do not have any problems like that in our family, or miscarriages or anything, and I have had aches, pains,

and discomforts, but luckily, everything has been fine so far. That makes me have an optimistic view of childbirth just because everything seems to be fine so far. At this point, I am allowing myself to believe it will continue to be fine. I do not know whether that is true or not. We will find out . . . I am not necessarily sure that I buy into the women's intuition. I think it is important to be in tune to your body and that may be a better approach to take, to just be aware of what is going on with your body. And have as much knowledge as you can about things rather than assume that you know things that you don't. Of course, birth is a natural process and people have been doing it for thousands and thousands of years without classes and doctors or drugs or anything like that, but I think that natural processes are not necessarily, I mean, nature doesn't always turn out how we would like it to . . . There is more un-natural. Just being aware of certain things, interventions in nutrition, prenatal care. I think it is important to be both, to be aware of what is going on and to be aware of what you can do to increase the likelihood of an outcome.

Kayla (Interview I, October 13, 2003) also doubted her own sense of knowing, intuition, for birthing:

Probably I am not going to know what to do. They say it all comes natural, but I do not know. Now weird things are happening, any tiny little thing. When I started bleeding, I did not know what that was. I ran to my mom. I thought I hurt something. I do not know everything. Weird feelings down there, I guess it is the baby putting pressure or something. I do not think I know. How am I supposed to know if I am in labor? I do not think I probably will know what to do once I get to the hospital. I will breathe, like

watching all the TV shows. They tell you to breathe. Just push! Do what the doctor tells you.

As she compared it to her wedding, Sophie (Interview I, November 19, 2003) described her inner wisdom in this manner:

Just kind of letting go. I feel like these Internet articles of women who were so disappointed and so let down for not being able to give birth naturally. They are devastated to the point that I feel it contributes to postpartum depression that could possibly be there. They have this beautiful baby . . . It is like my husband and I when we were planning our wedding, we forgot the whole point that we were getting married. There is this whole other side to this. There is this product at the end. That is what you are after. It is a stretch. My being able to say I am just going to do my best. I feel like I have done some research on the hospital. I have talked to everyone that I can find that has had a baby at this hospital, the nurses there. And my doctor, I have talked to him at length . . . I want to feel like I can trust him. And let him guide me through it. I have never done this. I do not feel that I am more knowledgeable than my doctor who has done it is. I can tell him what my preferences are. Just being able to let go, losing some of my tension to begin with and not feeling I have control over the whole situation. Everyone around me is worried about the same thing I am and having faith in them. It is easier on me than everyone else I feel, a lot of the time. You have made me think about things that I had not thought about.

Sophie's perception of her intuition is interfaced with issues of control as she says she will "let go" and not have to feel "in control." Because of her lack of experience, she trusts her

doctor. There is a sense that she must yield to the care providers because she is having an easier time than they are.

The nine participants were in their second or third trimester of pregnancy during the first interview. They expressed varying degrees of intuition surrounding the birth of their baby. The examples of these first time expectant mothers ranged from no belief of existence to ambiguity, discounting, or relinquishing their intuition or inner wisdom. Several of the participants used their mother to validate their intuition. Most of expectant mothers were doubtful of their intuition. While some childbirth education organizations contend that women possess an inner wisdom as it relates to birth, the experience of most of the participants did not confirm that knowledge.

Expecting Birth: Control

The issues surrounding control related to birthing were two-pronged: expectant mothers spoke of how others had controlled the amount and type of knowledge they were receiving from childhood to adulthood and dilemmas related to the struggle of communicating needs and preferences as a result of an increased knowledge base by the expectant mothers. Because pregnancy is time limited, temporality subjectively constitutes the cognitive and emotional threads of feelings and thoughts. The participants shared that friends, family, and healthcare providers often withheld essential information about the experience of birth.

When asked about how she acquired prior knowledge about birth, Sophie (Interview I, November 19, 2003) stated that she needed details. Identifying her mother as a limited source of knowledge, Sophie said, “[From] My mom, I guess. No one else seemed to talk about it. I do not know if it because of the general anesthesia. ‘You will be fine.’ That was all I was ever told. You cannot get the details. My mother never gave me the details.”

Although she had not yet read the educational literature given to her by her midwife, Shantell initially (Interview I, October 9, 2003) revealed that she would attend childbirth classes at the hospital where she planned to have her baby. However, at the time of the second interview (November 6, 2003) she expressed the following sentiments:

My mama changed her mind about the childbirth classes. She says I do not need that. . . she did not go . . . I might go. My auntie did not go either. Next year at school [high school], I will take classes about having babies, but I haven't had that yet.

To discourage Kayla from getting pregnant (Interview I, October 13, 2003), her mother and friends taught her that getting pregnant was a negative experience. Getting pregnant was something she should not do. Kayla shared her experience of limited learning about birth:

My mom always told me bad stuff so I would not want to go out and do it. I really did not hear much about it. Our family was strict on the boy situation. I was not allowed to date so they never mentioned it, except that it was all bad. Makes you not want to do it. When I was a little girl, I did not hear much . . . your friends tell you this and that. They do not tell you about morning sickness and they do not tell you about the nights you cannot sleep. All of a sudden, out-of-the-blue, you have to use the bathroom because the baby is sitting on your bladder. It is different from what you hear. You have to experience it yourself to know because not everybody can tell you exactly what it is.

Anna (Interview I, October 9, 2003), a college student, shared this memory of learning about childbirth from her family when she was younger:

Nobody really told me directly. It was more what I overheard. You know when you are a kid no one ever tells you about having a baby. I am sure you know [I heard it from] my friends' parents. Friends my age talk about it with other girlfriends. If you asked anything

of my mother, I do not remember asking anything. In my family, it was almost as if, if you talk about it— a lot of women in my family thought it was contagious. If you talk about it at a young age, then you don't need to know. She doesn't need to know. They thought it was contagious.

Erin (Interview I, January 6, 2004) explained her situation with these words:

No. [I do not remember my mother telling me anything about birth when I was young] it may be that my mother did the same thing [withheld information] as far as sex went. She firmly believed that talking about it was equivalent to giving permission. So she never did. It could be along those same lines. I do not know. I do not recall her ever saying anything or there ever being any education until puberty when it was sex education.

Olivia (Interview I, October 24, 2003) a graduate student in women's studies, recalled her experience of learning her mother's message:

Mom was involved with preaching to us about sex and that sort of thing. Probably when I was 11 or 12 and my brother was 9 or 10, she would bring books home and we would read them together. She was very good about educating us about that sort of thing. It was always pretty clear. Our family is Roman Catholic. It was implicitly clear that the time for having babies is when you are married. She always encouraged that at a later age.

In her ninth month of pregnancy, Harper (Interview II, January 20, 2004) a self-described feminist, changed obstetricians and hospitals due to her dissatisfaction with her physician. She shared this experience after touring the hospital where she initially intended to give birth.

The hospital has all these other classes, "Birth and Beyond," "Feeding your Baby." I can figure all that out. I want to know what to do to have the baby. I did

not find that was very forthcoming. You go to the hospital and ask do you have a whirlpool? Oh no, we do not have that. Do you have showers? No. Do you have a birthing ball? No. There was no response of we don't have that, but we do have this option. You can bring this in. You can use this. Not at all willing and ready to give you information. It is like a secret society thing. Not until you go through the horrors of it, are you inducted into the club. It pissed me off. You know what things they pushed? We do have a mirror, a full-length mirror that you can see the baby. I would like to kill them! I would like to get through it drug free. Now that is my goal. I could not care less about the full-length mirror.

Harper's experience reflects an interaction with a hospital nurse who did not seem interested in helping her get the birth environment she envisioned. She felt the nurse withheld information from her and was not even willing to compromise.

Harper (Interview II, January 20, 2004) then expressed her feelings about friends in the health care field not being forthcoming with information about birth, physicians, and hospitals.

[My friends were] not at all willing and ready to give you information. It pissed me off . . . I have other nursing friends; I could just choke some of them. One of my best friends, R. I told about switching hospitals. Great relief comes across her [friend]. "I am so happy you switched." If this is how you are feeling, then why didn't you tell me about the other hospital when I first told you? She said that I seemed to have my mind made up. When did I ever seem to be the type of person who would not consider your opinion? This is not my profession. This is your profession. Why haven't you said anything to me?

Erin (Interview I, January 6, 2004) described her husband's response to her asking questions of her obstetrician. Lists of questions will make care providers think she is crazy.

He [her husband] thinks they all think I am crazy because I come in with lists of questions, and I do not think it is true to that extent. I do not think that I am that uptight. I think it will be okay. I do not think there is going to be any problems with that. I think most people appreciate some level of understanding. As long as I don't go in thinking I know more than they do, which I definitely don't and acting like it. It will help me to make informed decisions when they come up and be able to interact a little bit better with people when they talk to me. I do not think it is something that will be a negative. I think it will be positive.

Erin's husband may have been embarrassed by the number of questions she asked her doctor. She may have felt that she should also factor his reaction into that interaction with her caregiver. That reaction may have also limited or controlled Erin's ability to get the information she needed.

The participants identified examples of knowledge control by others as it influenced their learning about birth. Eight participants shared nine illustrations of dilemmas they had encountered because of their knowing. The expectant mothers were resentful, in many cases, of knowledge being withheld or controlled. When they had information that caused them to question medical-based practice related to their birth, most remained passive. Only Harper used a position of assertiveness or pro-action. Certainly prior knowledge and perhaps current knowledge were not empowering if the environment where that knowledge was applied was not viewed as supportive by the expectant mother.

Many of the expectant mothers had concerns about their lack of control related to their birth. Utilizing knowledge about birth options was a challenge. This frustration was attributed to their learning.

Initially, Olivia (Interview I, October 28, 2003) expressed feelings of frustration related to her new knowledge like this:

One of the parts of knowledge that I have taken away from reading. . . no matter how prepared you think you are or whatever choices you think that you want to make about what is going to happen, there is really no certainty in it. Reading articles about women with elaborate birth plans having things go very differently.

From Olivia's journal entry (Journal Entry 2, no date) she noted:

When I was about three months pregnant, I went for my initial appointment with my obstetrician. At that appointment, she asked me whether I wanted to have an epidural during labor. I felt that she expected me to answer her question but I did not feel able to. I have not given birth before. I do not know what labor feels like. So how am I supposed to know whether I will need pain medication to endure it?

Since I became pregnant, I have read a lot about labor and pain medication. I know that it is healthier for me and for the baby to labor without pain medication and I want to be able to remember how it felt to see, hear, and feel my baby being born. But I am very anxious about the amount of pain involved. I have heard a lot of stories from women who have given birth. Most assert that it was the most pain they have ever felt. Even my mother, who gave birth to me and my brother without pain medication, told me, "Don't be stupid. Take the drugs."

But these stories do not really prepare me for the pain of labor. Even women who have given birth are unable to describe the feeling to those of us who have not given birth. If I only knew what it would be like, I could decide whether I will want pain medication. I explained my indecision to my obstetrician and she told me that I could decide when I

was in labor. For most women who have not given birth before, it seems like this is the only decision they should make about pain medication before going into labor.

Harper (Interview II, January 20, 2004) related her frustration and disappointment with her life partner for suggesting that they consider having a Pitocin (a synthetic version of oxytocin, a hormone that stimulates the uterus to contract) induced labor during a recent visit to the hospital with premature labor:

[My partner] does things that she thinks are supportive, but they are really forms of coercion. I think she would love me to have gone on Pitocin. She kept saying we have been here so long! Don't you want to go home with the baby! Yes, that is why I tried the Cytotec [medication that effaces the cervix]! I am not doing the Pitocin! Especially after listening to the nurses. The whole time we had been there, talking about they had been pitting another patient for twenty hours. It does not even sound nice! You are operating your whole pregnancy out of fear. I will do whatever the doctor says. I do not know anything. It is terrible. Why do we need to make women afraid? Because we can control them better. Keep people ignorant and down. They are much easier to control. The worst thing they ever did was let us go to college!

Lilly (Interview I, October 28, 2003) believed that her knowing gives her choices, yet at the same time she felt under the control of the health care professionals.

[Knowledge about birth] makes me want to be a little more in control. I know you cannot ever have a 100 per cent birth plan. And I am not going to have a birth plan. It does make me start thinking about something as simple as maybe I want a candle in the room. The music you like to listen to . . . When you have knowledge, it lets you choose what you

want. Whereas if you do not know and you are not educated and you do not know your options, you are just going to get the pediatrician who is closest to you, without the same ideas. He is going to come and do whatever he wants. You are going to be under their control for your delivery and the first couple of days with the baby. Then you are just thrown into it all. Where if you do educate yourself, you can pick what is best for you.

She continues to describe her experience of conflicting issues surrounding control as she attempted to define her role in the birth of her baby.

To get the baby out! I hope that is my only role! Everybody else does everything for me and then I just have to birth the baby. I know a baby births itself and all that. You don't know and you can't say, but I would like to have absolutely as much control over this as I possibly have at that moment, because I don't want a doctor to come in and say "Oh honey, you are in pain; let's give you an epidural. Okay, contractions, let's do Pitocin or whatever—oh this, stick in this, that."

Doing this, doing that. I would like it to be as natural as I possibly could without – having a home birth. At that moment, I know now it is easy to say that I am not going to have an epidural. I know at that moment; it is much different.

Three participants gave five examples that acknowledged their feelings surrounding the complex issues of their perception of lack of control when giving birth. Even though knowing what is best for them seemed reasonable and realistic, there was doubt such justification would prove viable. As sound as the espoused rationale may be, in the reality of the practice setting, it may not work for them. Within the arena of the medicalized birth model, the more involved an expectant mother is in her birth experience, the more likely she is to experience confusion and increased anxiety (Berg, Lundgren, & Lindmark, 2003; Green, Coupland, & Kitzinger, 1990).

However, a well-supported midwifery model of care has the potential to create a peak experience that can positively influence a woman's life (Humenick, 2003). The expectant mothers' concerns are valid and demand an implicit need for them to remain flexible and yielding during birth.

Expecting Birth: Hopefulness

When asked to describe their anticipated birth, the expectant mothers frequently used the term "hopefully." In retrospect, it was easy in many cases to interchange the term doubtful for hopeful. There seemed to be an air of skepticism, especially after listening to the audiotapes again. This term was used in reference to positive birth outcomes as a result of their knowing for these first time mothers. Even though Kayla (Interview I, October 13, 2003) had no idea how long a first time labor should be, she said "I hope I am not in labor a long time."

Anna (Interview I, October 9, 2003) chose these words related to her birth knowledge, "I am hoping my knowledge will make my experience better. Because if I hadn't done this research, it would have just been something that I did not know about."

Harper (Interview I, November 11, 2003) described the impact of her knowledge on her birth, "I am hoping that it makes it what I want it to be ... If something happens and I end up in excruciating pain and I cannot take it anymore, I would rather have the IV. Of everything I have read I would rather have the IV I had rather it not be Demerol. I would rather it be something a little less than that. But, I will go for that before I do the epidural. . . .I am not saying nothing can change. I do have some ideas how it should go."

Lilly (Interview II, December 12, 2003) a marathon runner and former sales representative shared her vision of her "perfect world birth."

I stay home until I am four to six centimeters. None of this is carved in stone because the baby has its own agenda. I would go to the hospital and hopefully everything will be

packed and organized. I will have all my favorite things. I would go in and probably get an epidural and you know my favorite people would be there. You have to push. You get tired. You get a little sweaty. Then the baby comes out. Hopefully, I do not need an episiotomy or any of that stuff. Then somebody will clean me up. Hopefully, I can take a shower, but I don't know. Oh, hopefully I get some kind of walking epidural so I can at least move. I am hoping everybody comes in my room and does everything to the baby so I can watch. I want to breastfeed immediately after delivery because I know [the hospital nurse] said that your best chances are to breastfeed immediately afterward.

Erin (Interview I, January 6, 2004) described the way she thinks her birth will transpire. I hope that wherever I am, I can come home, stay home for a while, and keep timing them [contractions]. My husband has his timer and his chart. . . . I think, hopefully that will not be too uncomfortable. I hope that I can stay here where I am relatively comfortable, where I can move around. . . . Hopefully, we can use some of the techniques we learned in Lamaze, the massage, the baths, heating pads. . . . Hopefully, I can relax enough even to rest before we get to the hospital. That is really my goal. Not to go to the hospital until I absolutely have to, because I know I am going to be uncomfortable, more uncomfortable there, just because I am in a hospital . . . hopefully, that is how the first part will unfold.

As seen in these women's quotes, five of the expectant mothers used the term hopeful in describing their anticipated labors founded on their knowledge about pain management and birthing options. Use of the word "hopeful" should give the impression that they are able to see personal choices and mobilize energy on their own behalf. However, it may be more accurate to

see this sense of hopefulness as a strategy to help the interviewees cope with their perceived lack of control regarding their impending births.

Expecting Birth: Conflict

Specific feelings of interpersonal and intrapersonal conflict resulting from knowledge gained were revealed in five participants. The expectant mothers explained that their knowledge influenced their desire for a natural birth, but they were afraid that they could not do it. Having information did not reduce conflict for the participants; in fact, information may have increased conflict.

Shantell (Interview I, October 9, 2003) shared her conflict surrounding her need for pain relief and avoiding the side effects that her mother has told her about:

I don't think I can have my baby without all those things the doctors do because my mama did not have any medicine. She says it can paralyze you. My auntie did and my mama said it is not good for you. But, I am not going to try it without it. My auntie says it is easier than if you don't get it. If I am there for a long time, I need them to tell me if I am dilated. I know I have to go to ten centimeters before I can have my baby.

Since Anna (Interview II, November 6, 2003) will be moving out-of-state, she started attending prepared childbirth classes early in her pregnancy of twenty weeks. She has a dilemma based on her perceived need for medication and what she has learned from attending childbirth class. Anna felt this way:

Because I have not been through this before, I hear everything. I am going to lean on somebody. I have no idea what to expect. I feel torn between the decision of not having any medication and leaning more towards medication, only because I went to my childbirth class. [The childbirth educator] said most people do not need it.”

Some information, such as using a birthing contract, may make a mother appear demanding or give an impression of a false sense of security. Sophie (Interview I, November 19, 2003) expressed concern about the information threatening her relationship with her physician:

I know the birthing contract makes him crazy. Because he said, "I am going to tell you everything along the way." In a way, I think it makes you feel like you are too informed. I have a lot of faith in the doctor. That is how I feel. I told him I know that you have the best in mind and ultimately we have the same goal, to have a healthy baby. If there are forceps, or any episiotomy, I might be disappointed if we have to cut or anything. I would imagine that it makes them feel like they are second-guessed . . . I am not going to be very controlling. It sounds like many of the women go in there very controlling. I am not going in there trying to control this.

Undecided about medication, Olivia (Interview I, October 24, 2003) expressed her feelings about labor pain in this way:

At this point, I am not sure whether I prefer to have a natural childbirth or a medicated one. I do not want to set myself up for disappointment by not being able to do it naturally. There I feel a conflict between my feminist views and the medical establishment, but at the same time I understand the arguments for natural childbirth, but I also feel there is a tremendous amount of pressure to do that. The only major medical procedure involving so much pain and you are expected not to have anything. I am trying to keep my options open and not pin myself down to a specific idea as to what is going to happen.

In her journal (Journal Entry IV, no date), Olivia shared her mixed feelings and concerns about her pregnancy:

Since I became pregnant, I have had to adjust those very positive expectations of what pregnancy would be like. Emotionally, I have been very happy about the impending birth of my child, but I have been depressed due to the discontinuation of my antidepressant medication, worried about my financial situation, concerned about my ability to take care of a baby, and anxious about the effects of parenthood on my educational and career goals. Socially, I have received lots of positive attention from my husband, family, friends, and colleagues, but I have received some negative attention from them, too. My husband is feeling the same amount of stress as I am and we have had a lot of arguments about finances and childrearing. My family and friends have been less involved than I expected because they live so far away. Some of my colleagues have tried to assist me with my educational and career obligations during my pregnancy, but others have not. And physically, I have been extremely miserable for the entire duration of my pregnancy. I have had persistent morning sickness, cramping, spotting, sciatica, severe round ligament pain, clogged milk ducts, a sprained foot, and insomnia. I have not really been able to enjoy my pregnancy and I cannot wait for it to end. Now that I am in my eighth month of pregnancy, I have been having conflicting feelings. I am so tired of being uncomfortable, and I am so ready for my pregnancy to be over.

Olivia also related her desire to have an active role in her birth during our first interview (October 24, 2003):

I would like to have an active role. I see this conflict between the medical profession and one of my own background. I would like to be able to be in positions that are most comfortable, most conducive to labor – to have some say if I have a cesarean birth or not, whether I have drugs or not, a lot of the decisions that are made as far as the care that is

given. This is part of the reason I was considering having a doula, just to have an advocate there, because I do feel comfortable with my doctor, but I am also feeling uncomfortable bringing up things. Even things that are prevalent in the literature, like being in an upright position to let gravity help with the delivery. Things that are disconnects from what childbirth experts tell you to do and what is acceptable as far as the medical field goes, I think are difficult to bring up . . . being worried about how your doctor will respond and not wanting to damage that relationship with your doctor. That is how I would ideally like to participate. To have my husband be actively involved and have some say over the decisions, although I have come to realize that may or may not happen (laughter).

After investigating numerous evidenced-based birthing options, Harper and her partner approached their obstetrician regarding their birth plan. She recorded these thoughts in her journal (Journal Entry, November 19, 2003):

What are we going to do? We brought our birth plan into the doctor today. First thing she said was, “A birth plan? A sure sign of a c-section.” She really can throw you off. She made fun of us as she read our plan. Maybe this would have been different for me if she had in all the months of appointments ever warmed up to us – had the kind of relationship with us where she picked on us for being too serious—but that is not the case. She has always been standoffish. Our birth plan was not final. It was a rough draft to discuss with her and ask questions . . . We were both in shock when we left her office. She had us scared to death and I am in my 31st week. I don’t want this doctor around me when I deliver. We have a huge dilemma – stay with Dr. X and fight her all the way to delivery or find a new physician this late in the game. What are we going to do?

Four expectant mothers shared five examples of conflict. This conflict was shrouded in indecision related to personal expectations and meeting the needs of others. While pain is a powerful phenomenon, in many circumstances, it is an indication that there is something wrong occurring within the body. Although the pain of childbirth is normal, it is universally feared by women. Labor pain had been cited numerous times previously, three examples of interpersonal conflict were inclusive of issues related to pain management and subsequent decision-making. Each example has at its core the issues of communication breakdown and distrust.

Expecting Birth: Confidence

In response to the question, “Describe your ability to give birth as it relates to your confidence,” many variables affected each of the expectant mother’s perceptions of her role in the birth of her child. A wide range of birth confidence was described by the participants. During our second interview (December 12, 2003) Lilly said, “My confidence level is one hundred per cent! . . . I know I am going to be able to do it (give birth). The baby has to come out.”

Harper (Interview I, November 12, 2003) explained her position:

[Caregivers] scare you into making you think—the technology is here, not at your home. If something really happened what would you do? They scare you about midwives. Fear is a big part of it. The first time I arrived at any knowledge, other than whatever was mainstream, was through my women’s studies professor. She had a class, "Worlds of Women," one of them was about childbirth . . . She talked about owning your experience, owning your body. I guess for the first time in my life, I questioned it. Just coming out and being a Lesbian, I would have a light bulb go off, but it does not. It is a slow process. I told my partner to stop operating out of fear. She is an educated woman, for God’s sake. She needs to stop letting people scare her. It is the great unknown. What was

funny was when I felt like M was not being proactive; I really relied on my nursing staff. I was greatly amused by them. Every one of them said don't do Pitocin. All of them said follow your birth plan. Stick with your birth plan. Don't let this wear you out. This is nothing. If you cannot stand up to this then you won't be able to stand up to it when it is really happening. They were excellent. Do not do anything out of fear. Do not let anyone scare you. No matter how justified it may sound or seem. No matter whose experience was bad; somehow, that discolors birth entirely. Surround yourself with people who are going to keep you in charge, who are going to keep you in the power.

When asked to describe how she believed her knowledge would be accepted and valued by her caregivers, Anna (Interview II, November 6, 2003) expressed:

Before now, I would not have known my body parts below my waist. I would have never known what an episiotomy is. Now I do. I would have had no idea . . . I am not just talking about health wise or anything like that. I have always been interested in learning more. Because this is such a long period, I will probably get a little more in depth than I thought I would. I do not know. I thought I was going to get everything on the surface, and not have to really dig as deep as I had planned to . . . I do not know how to change diapers and I need to know that. You know I told you that my mom was not coming around fast enough, so I would use the computer. Now that she is, I will have her knowledge as well as the knowledge I have gained from the literature.

Jenn (Interview I, November 24, 2003) was in the process of attending prepared childbirth classes with her partner. She shared the following:

I think I have had some experiences that are not typical, especially for my age. I would not go back and erase those experiences because they made me who I am. They have

made me stronger and made me less naïve. . . it forced me to grow up in some ways more than someone my age has done . . . maybe they never will. I would rather do things on my own, usually. I am confident that I can do this. I have made some different decisions. . . I am sure there are going to be days when I say I cannot do this!

Jenn (Interview I, November 24, 2003) continued to say:

I am confident that I can physically do it. I do believe part of that is just knowing that I am not sure. Just having gone through everything in my life up until now the pregnancy included and knowing that it may be hard, but I can make it through. As my father told me, it is a little late now so I cannot back out at this point. It is a natural thing. There are people that do it every day. It may not go the same way that I envision it, but it will happen and I will make it through it.

Jenn had given birth one week before the second interview (January 26, 2004). We started our interview with her birth story. At her doctor's suggestion and her consent, Jenn's labor was induced with Pitocin because her physician was leaving town. Because Jenn had less than twenty-four hours to mentally prepare for the induced labor, she did not sleep well the night before reporting to the hospital. She described the labor as "not being restful." She related her birth confidence as "Probably lower than it had been previously because she wasn't sure what to expect."

Olivia planned to attend childbirth education classes and had done "extensive reading on her own." She explained her sense of confidence before giving birth (Interview I, October 24, 2003).

I think I worried about it pretty much even from before I ever got pregnant. That was something I worried about as far as having kids, how hard it was going to be. The farther

along I got that became less important. I guess I was more impatient than anything else was. Once I started getting into the ninth month and beyond, it was more let's get her out. And whatever happens, happens. But, I definitely have some concerns still going into it. Nine days after giving birth, her perception of confidence had changed (Interview II, January 19, 2004). Olivia's labor was induced with Pitocin because she was:

about five days late . . . I hadn't really made any progress . . . my mom was in town for a limited time . . . I had a lot of amniotic fluid so [the physician] thought the baby was going to be a lot bigger than she was.

The position of the baby's head was resting against her spine, which gave her back labor. Consequently, her labor pain was more intense than she thought it would be. Olivia elaborated on her post birth confidence level:

I think I felt confident, but I, I guess I felt like I knew what to expect, but the pain was a lot different. I felt confident that I could endure the pain of labor. It was a little disappointing to not be able to do it. I tried to do it for a few hours and it was a little bit upsetting that I was not able to do it naturally. I think some of the descriptions that we talked about were accurate as far as being like menstrual cramps, but much more severe, but it is hard to describe (laughter). I guess the thing that was hard for me was that it was impossible to get away from. It just seemed to be impossible to escape.

Harper (Interview I, November 12, 2003) stated that women, in general, do not have "enough self-assurance in their own ability." She portrayed her own confidence, which was embedded in her perception of caregiver control, with these words:

There is a part of me that is scared of having the baby in the hospital. There are so many ways they can intervene. I feel like I am in a police station. If I get up to walk, they are

going to call the psych unit. I feel like my choices are going to be limited. I do not want anybody interfering. I want to make sure that I can do this. I can do this.

Kayla (Interview II, December 12, 2003) related her life experiences of being injured while playing softball and participating in dance team with an injured knee with giving birth. She assured herself with the following statements:

If I put my mind to something, I can do it. I can do it; I am ready. You do not know what is going to happen. I put my mind to all of that. I dealt with it. I went through a lot of painful stuff. You have to deal with the pain. If you are going to do this, you have to learn to deal with it.

Lilly (Interview II, December 12, 2003) has “always considered herself a strong person” but she is reluctant to put “expectations” on herself for her birth. She uses her running a marathon as analogy.

I am not putting strong expectations on myself because I do think that is sometimes where you falter. When I ran my first marathon, I did not say I am going to run it in 4 hours and 10 minutes. I went and enjoyed it and just took it easy and had a lot left in me in the end. I enjoyed it, did not go out with this weird expectation and be disappointed.

That is the only reason why I do not say 100% I want to have a natural birth. I have not told anybody that because I will know if that is what my body can do. As far as labor, I am not one bit worried about making it through. I am a little worried about the pain.

Some people say it is just so amazingly unbelievable, but as far as getting through, I am not worried about that. First of all, the expectation thing of it. . . I have read about women who go in with these strict, stringent plans of how they want things to go. A very large percent of them end up having an unsuccessful experience for themselves. For instance,

you prepare yourself for a vaginal delivery, you put all these restrictions on yourself, and you end up having a c-section. There is literature written about that. If you are too this, then you can end up, like in the book I read the other night. It said two people who have the most problems with delivery are people who expect the pain too little or the people who fear it too much. They are the two opposite ends of the spectrum. I don't know why I haven't; maybe because it is the unexpected . . . Would I be shocked if I did have pain medication at the end, no, no. But, I know deep down inside what I would like to do, but I do not want to put that restriction on myself because I do not want to ruin the experience for myself.

Eight of the nine expectant mothers gave descriptions of their levels of birth confidence. Their words initially supported a picture of "high birth confidence" in their body's ability to give birth. However, the absence of inner wisdom or intuition may negate any physical confidence they possess. As a compensatory mechanism, many expressed the need to have a lower level of expectations for themselves and their experience so as not to disappoint, perhaps themselves. For some, the knowledge they had gained held a value that gave them a higher level of ownership in their birth experience.

Connecting and Disconnecting: Mother

All nine participants described a relationship to their own mothers as it related to their experience of pregnancy. This connection ranged from an emotional one to an informative one. Most of the relationships were discussed as positive. All participants were expecting help from their mothers in various ways. These thoughts are reflected in the following statements by the expectant mothers. Shantell (Interview II, November 6, 2003) said, "My mama is going to tell me when to go to the hospital. She is going to tell me everything I need to know." Another

participant, Jenn (Interview I, November 24, 2003) said, “My mom tends to be the one I go to ask for advice about things.”

Kayla (Interview I, October 13, 2003) described her need for her mother in this way:

I am always dependent on somebody because I am an only child. I have always had somebody to give me everything. Now even. But emotional wise, I always have to depend on someone else. I cannot do the emotional stuff by myself. I have someone to talk to about that like my ex boyfriend, who is still in my life. He is the one who helps me through a lot emotionally. My mom, I talk to her a lot too. Some things you just cannot talk to your mom about though . . . My mom will be there; she can help me. If she is not there, I do not know what I am going to do. She had better be there. That is my support. I want her to be there.

Even though Olivia’s (Interview I, October 24, 2003) mother lives far from her, she “talked to [Mom] the most; I guess the only draw back is that it has been so long since she had babies. A lot of the advice she had was outdated.” She described her relationship with her mother during her pregnancy:

I call her a lot, often for sympathy. When I had morning sickness bad, my husband and I had gone out for ice cream and I could not even finish my ice cream cone. I was so sick, I need to call my mom and thank her for going through all of this. I called her and she said “Morning sickness, no I never had any of that!” (Laughter). That was interesting. That was something else I learned. I expected to be a carbon copy of my mom’s experience. Finding in the books that not all pregnancies are the same. Since then, I did find that she had the same kind of mastitis problems. I told my husband that I wish she could be here for the birth. That is kind of a sore spot with him . . . He has told me that if I really want

my mom, and she is able to be here, he doesn't have a problem with her being in the delivery room. That is kind of an injury to his feelings. He feels like that is his role. I would like her to be, but I don't think she will be able to.

Olivia's mother was able to attend her birth and in describing the experience, Olivia stated (Interview II, January 19, 2004):

The most important is the relationship with my mom because she was probably the person that I ask for advice the most. And compared experiences with the most. I did not think that I would want her in the delivery room when I was actually giving birth, but I am glad she was there. That was probably the most important.

Harper explained her feelings of disconnecting with her mother in this way:

I am my mom's only child. I worry about her. She is not a well person. She is strange. I am not going to leave my baby with her. She is acting like I am going to let her watch the baby. My mom wants to be there, but I know she is not anybody I can count on. Even though my mother wants to be there, my mother cannot do that for M [partner]. You cannot rely on that even if mom says she will do it. When we left [childbirth] class last week, M said what happens if I need to go to the bathroom, I think I am going to need your mother there. You ought to think of someone else you want there. Mom could say she wants to be there and never show up. We would never be able to find her. She would never answer the phone. Or she has a migraine and cannot make it. You cannot count on her for that.

Sophie (Interview I, November 19, 2003) described her relationship with her mother this way:

My mom she is outdated. . . She had never heard of an LDR [labor, delivery, recovery room] delivery and it would be too much for her to handle. She had to sit down for that one.

Sophie (Interview II, February 28, 2004) gave birth three weeks before her due date. She explained her connection to her mother:

My husband was so worried that I did not call him first. Isn't that funny! I am a little too close to my mom. She really wanted me to get the epidural. She told me, "Why are you making things so hard? You make everything so hard." I realized I do make a lot of things difficult.

By the time of the second interview, (November 6, 2003) Anna had changed her plans to return to her grandparents' home to give birth. Anna shared, "My mother said I need you to be around me at this time. It did not take much for me to realize that I need that—to be with my mama."

Every pregnancy influences all family relationships. The mother of each participant used overt and covert ways to communicate her feelings about her daughter's pregnancy. Because all nine participants related their knowing in childbirth to a maternal connection, numerous examples of this need were expressed. The expectant mothers expressed the need to have a positive, reliable connection with their own mothers. This relationality with their mothers was evidenced in other data as well. Pregnancy brings with it increased dependency needs for nurturing and support. These needs may be an effort to connect again with their mothers. The participants experienced joy, concern, and stress, no doubt similar to those feeling experienced by their mothers (Lowdermilk, Perry, & Boback, 2000).

Knowing: Birth Story

None of the expectant mothers remembered hearing stories about birth as a child and none remembered reading books about it. Harper (Interview II, January 20, 2004) shared this feeling about children's books, "There ought to be more books about it for children." Jenn stated (Interview I, November 24, 2003), "I don't remember hearing stories about childbirth as a child. Not really until later in junior high or high school. I don't know that anyone ever went into detail." Anna observed recently (Interview II, November 6, 2003), "When somebody notices you are pregnant, they always have a story for you."

Lilly denied remembering stories from childhood but shared this first hand experience (Interview I, October 28, 2003):

I do not really remember hearing any stories. Not really. I saw a birth when I was seventeen, which sounds young to me now. Nothing really stands out. You always hear that it was painful. I do not know why that episiotomy thing, the tear thing, stands out. Since you are little you always hear that it is the most amazing thing you will ever watch. Until I saw one I really did not know exactly. I cried when I saw the birth. I was seventeen or eighteen . . . my nephew. . . was born. I remember the one thing that amazed me so much. I do not know why, the baby's head pushes in when it comes out of the mom. It does not stay round. I do not know why I was impressed by that.

Lilly (Interview II, December 12, 2003) later described a party she had given. She invited significant women in her life that had given birth to come and share that experience. They were to bring a bead for each of their children that would make a bracelet for Lilly to wear in labor. This was her narrative.

Each bead and accent bead symbolizes the birth of these people's children. It was neat to see because everybody sees their pain and their feelings and everything in a different way. Many of the people who were over here, it is different, the emotional side of them came out and the very analytical side. Some women talked about the emotions of it and how awesome it was. Some of the women were very analytical and talked about the drugs and the pain. It is different depending on people's personalities; how they describe the birth of their baby. I know that is going to be a big help because when I ran my marathons, I had a little talisman with me. A little pen that someone had given me, a prayer card in my fanny pack. Whenever times got tough, I would reach down or look down and think this person is with me. I know that is going to be a big help.

Jenn (Interview I, November 24, 2003) recounted a later experience of watching a relative's birth video.

One of my mom's cousins, I remember, taped the birth of their baby. We all sat around and talked about it. How we felt about taping it and then watching it. It was kind of strange because that was before anybody started videotaping the birth of a baby and sharing . . . Her cousin and his family wanted everybody to watch it. I only saw a little bit of it. I thought, you know, it was kind of cool that they had done that. I did not particularly want to watch it.

Erin was seventeen when her older sister gave birth (Interview I, January 6, 2003). Erin shared her experience.

The biggest thing I hear is that, the labor part of it, and how difficult and how painful that can be. But that you forget it immediately, as soon as, they give you the baby; that is probably the thing that everybody says the most. And some people elaborate on the

details and I remember my sister saying make sure you get an enema before hand because she had a bad experience during labor. She had a long labor, and it was painful to her.

In addition, Erin continued with this impression of her mother's story:

People like my mom said she enjoyed being pregnant; she loved every minute of it, and it was the best experience of her life. I think most people in my family have said the same thing. That it was an enjoyable experience for them being pregnant, the delivery part of it. Then they start telling me that it was painful.

Erin's younger sister had two children. One child was born by cesarean and the other was a vaginal birth. Erin retold the details of her sister's birth experience (Interview I, January 6, 2003):

She told me about the deliveries and what was good and bad about each. Some of the things that people tell me about their experiences would be like her first delivery. She felt that the people, the doctor, and the nurses were not very nice to her. She delivered in a military hospital; her husband was in the military. They were mad at her for screaming. They yelled back at her! Things like that. So she was. . . sad. You hate to be in that situation. You are already in pain and not feeling too well and here are these people yelling at you. All I could think of was, here she is going through all this pain, and these people around her are, I think her words were the doctor said, "You should have thought about all of this before you got pregnant." What a horrible thing to say to somebody! Instead of helping her, he was making it worse. You would hope that you would have all the support around you while you are delivering the baby and that it should be positive support. That was kind of disappointing. To me it makes you think about your obstetrician a little bit more when you go to pick one. Whom do you pick and is his type

of personality . . . To me, it makes you think about your obstetrician a little bit more when you go to pick one.

Harper (Interview II, January 20, 2004) recalled a story from her grandmother this way: I remember my grandma talking about this woman. She worked at a hospital as an aide for a short time. “And that bitch screamed and screamed and screamed. It was ridiculous. I said, if she can lie down to make that baby, she can have that baby and keep her mouth shut.” Grandma, what are you thinking? What is wrong with you? My grandmother really didn’t talk about her labors too much. You always hear “She didn’t get the episiotomy and she ripped. What is wrong with those doctors?” I hear horrible stories. I never hear good ones. I did not hear a good birth story until recently; my cousin had a baby. It was all about how perfect she is. She is the poster child for the perfect pregnancy, the poster child for the perfect birth. I hope I can do as well as my cousin. She [cousin] breastfed. When I saw her babies, they were real alert She said that is from not having anything [medication]. That is the difference. You see other babies and their mothers would give them stuff. They sleep all the time.

Sophie (Interview I, November 19, 2003) remembered her experience:

No one ever mentioned details. . . People always tell you about the horror stories. My mom actually told me about a woman at her work that had no pain. It was like this saint. Had no pain, I didn’t know if mom was trying to make me feel better. It was just all very vague like if there was a lot of pain or not. I wanted more details, to hear about her options, what was her position and that type of thing and that is not at all what they tell you.

In addition, Harper (Interview I November 12, 2003) described her need to hear birth stories in this way.

Tell your stories! This is how we decipher information. Then after you finish yakking about it, write it down and leave a paper trail. I do not understand the keeping of the information, locking it up and not saying anything. How are all the lay people supposed to know what the truth is?

Anna (Interview II, November 6, 2003) who is living away from her family and feeling “isolated,” also pleaded, “Share your birth stories. It comes with the package after you have a baby; you have to share your birth story with other people.”

Erin (Interview I, January 6, 2004) stated her need for hearing the birth stories of other women now that she is pregnant:

The details are interesting to me; so now, I would be more interested in them than I was when I wasn't pregnant or even thinking about it. Now those details are interesting. I think a lot of things are covered in general. You can get the medical details. Here is what is going to happen during labor, or here are your options. You can get that from books, magazines, Lamaze class. You can get it from that from the doctor even, but real life can really, not distort it, but it adds a lot to the experience if someone tells you the little details that have occurred along with those steps. You know the general sequence, because you have read about or were taught that in class. Someone might come along and say this is the point, I was scared, and you are not going to get that from a book or from a class. I think that would help me because I would say all right, I know this is coming up, and I know this is going to be a tough time. The emotions and things, you just do not get from anywhere else.

Twelve examples of birth stories were cited by the participants. In addition, three expectant mothers expressed the need for other women to share their stories with them. Story telling relies greatly on relationships and communication– it creates a bond between women and their shared history (Lindesmith & McWeeny, 1994). Expectant mothers' willingness to share their story is an expression of the universal need to explain the unknown, to lessen fear, and to obtain a sense of control over childbirth (Zwelling, 2000). Story telling becomes a vicarious learning experience when the expectant mother listens to the birth experience of another woman.

Knowing: Other Sources

All participants shared other resources for obtaining birth information. Most frequently cited were the Internet, books, childbirth classes, obstetricians, family, and friends. Most frequently used sources by the participants were their mothers and obstetricians.

To describe her motivation for getting birth information, Lilly (Interview I, October, 28, 2003) chose these words:

My own curiosity about things. I don't know that education level necessarily has anything to do with it. I want to know what is going on with my body. What is going to go on with my body? I guess you could say just being a conscientious person, too. There are women who are not curious, not that they don't care . . . That is what you do when you are pregnant, you just go to the doctor a couple of times, and that is it. Whereas for me, it has been very different. I don't know, I guess I had a strong desire to bond with my baby from the first minute I knew I was pregnant.

Olivia worked with several other graduate students who recently had children. She felt that "they were more willing to share their experiences than maybe she was interested in learning

about it.” It was as if they had “to justify” their birth experiences. Olivia shared her quest for learning about childbirth in this way (Interview I, October 24, 2003):

I will notice something physically in my own pregnancy that I have or a curiosity. I go to the Internet. It is a great resource to have. You can type in any kind of question, no matter how embarrassing! In addition, to get that kind of knowledge immediately and without having to find someone who had the same experience! I find things that I forget to bring up with my doctor. I can look that up on the Internet or some of the pregnancy and childbirth books. I find that a great way to supplement my consultations with my doctor.

Olivia wrote in her journal (Journal Entry I, no date) about her need for information:

In the first six months of my pregnancy, I was obsessed with learning all that I could about pregnancy. Most of my efforts were devoted to reading books and magazines about my changing body and my developing baby. I was more interested in those chapters and articles related to my specific stage of pregnancy and fetal development, less interested in those related to later stages of pregnancy and fetal development, and not at all interested in those related to labor, delivery, and childrearing. But, since the seventh month of my pregnancy, I have become less interested in books and magazines about my changing body and my developing baby and more interested in those about labor, delivery, and childrearing. This may be because the later part of the pregnancy has been less exciting for me and my husband. We have gotten used to my expanding breasts and abdomen. We have felt the baby moving. We have seen the ultrasounds. And, we have heard the heartbeat. We have become somewhat impatient with being pregnant and want to meet our baby girl.

Kayla (Interview I, October 13, 2003) shared how she learned about childbirth through others:

Classes through school [high school]. I have been reading magazines. The television shows on TLC. I watch that a lot, and that Discovery Health. Since I have been having problems that has been a help. They have shows where the mothers have problems, premature babies . . . I get information from my doctor. I guess she will talk to me some more. . . I am going to some classes with my mom.

Harper (Interview I, November 12, 2003) cited learning about childbirth in college. She chose these words to describe her experience.

I think my women's studies course was the first time ever. After I had taken the class, I actually knew someone who had their baby at home with a midwife. She had six friends there helping her have her baby and her little girl's name is P. It was a wonderful experience. That was a great story. I wanted to have a home birth after that.

Sophie (Interview I, November 19, 2003) said this about her experience of attending her childbirth classes.

There are so many agendas out there. And this is what my doctor was afraid of—don't take that Lamaze class; people have such agendas that teach Lamaze class sometimes. I think I put that word agenda in his mouth; he did not really say it. I know it is out there. . . My Lamaze teacher did not have an agenda. We were both so relieved. Oh no, is she going to make it so that if you don't go natural, it is just about the worst thing you can do? She did not make us feel that way. I think about half the class is hoping to not use medication. I pretty much take his instruction, is what I am after and being patient. I can see that now that I have taken Lamaze, the mystery is gone for a lot of it. I want to be told

I am in transition so I know that it is my worst part (laughter) I want to be told that type of thing. I just want to work hard, working and breathing, and getting through it. That is all. That is how I visualize it. The doctor tried to dissuade us. His nurse . . . really encouraged me to do it. I wanted to do it. I did not think they were mind-changing experiences in Lamaze.

Kayla (Interview I, October 13, 2003) shared that her mother was initially opposed to the classes offered at her high school on family living because she thought they would make the girls more interested in having babies than finishing their education. Kayla described what she learned in taking the class.

The main thing I remember from school and TV. In school, it was factual information. There was this one class in school we had to take, parenting/child development. In there, we had to get married, and we had a baby. We had to take a baby home with us that would wake us up in the middle of the night and cried. You had to sit there and act like you were taking care of it in school, in front of other people. They gave us factual information; they never said this is something you don't want to do. Whenever you are ready, this information was for when you are ready to have a baby. We saw videos. They only told us negatives about abortions. It was not good. They did kind of put that on you. The message was to be careful. If you do not want to have a baby, use protection. Everybody in high school is having babies.

Lilly (Interview I, October 28, 2003) shared her experience of finding resources about the birth process:

My mom and myself the most. Anything that I have educated myself on. My mom has been a labor and delivery nurse . . . I read magazines now that I am pregnant and I have

all the books. I use the Internet, not as much as I use a book . . . You can find absolutely two opposing views on the Internet . . . I find the Internet isn't as censored as a book or something that is publication that people have read. It is more widely approved or it just might have more of the mainstream view on things.

Since being pregnant, Harper (Interview I, November 12, 2003) acknowledged the following experiences of gaining knowledge about childbirth, "My doctor has been a good source of information. For me, getting scholarly journals, reading studies, I put stock in that."

Erin (Interview I, January 6, 2004) shared this experience of getting information from her doctor:

My doctor pretty much answers my questions and doesn't—I should say. I go in there with a list of questions and that pretty much takes up our time. He does not elaborate very much beyond that. He doesn't say here is what is going to happen . . . He tends to just answer my questions. It may be that we have not gotten to that point yet of talking about labor and delivery.

Having the experience of watching reality television and using the Internet has also been a learning process for Erin (Interview I, January 6, 2004). She said:

I have watched every baby show on Discovery Health and TLC for the last twelve months. I think I could probably deliver one! . . . I listen to the terms that they use. If some of those things ever happen to me then I will recognize them. I recognized a lot of the terms when they came up in Lamaze class from just watching it. A lot of that is just repetition; you watch it over and over. That helps too, because they are real people. You look at them and a lot of them are showing the emotion that you don't get from classes, books, or anything. You can look at the women and say I don't care what anybody says

that part of it must be very, very painful! . . . It is also more of a, you get a little more than just reading, you get the doctor's side, the nurse's side, and the woman's side, and the dad's too. I will sit there with my husband and say, "You see what he is doing to her—don't do that to me." [On the Internet] There are a lot of old wives tales and so it is hard to for me to trust, to trust in general what other people say. So much of it I have found has been completely false or just silly things people that people come up with about pregnancy. There is so much of it out there so I tend to stay away from chat rooms where you just get anybody and everybody coming in and saying anything they want, just sticking to the facts.

Jenn (Interview I, November 24, 2003) acknowledged her sources of getting information about childbirth:

Generally, my mom. Then my doctor. My mother is a good source of information for me. She is not afraid to tell me how it really is. My doctor, I do feel like I can, but I do not think it is the same because I have a male doctor. But, I know that he has been through it so many times. I am comfortable with him. I would go to my mom first; just because I talk to her most often, then probably my doctor . . . I use the Internet, TV, and Lamaze class. I have had I don't know how many classes in college on child development and that sort of thing. I do have some background information. I did take a class where we went into, not so much the whole childbirth part of it, but having a baby, what it takes to carry a baby.

After the birth of her daughter, Jenn (Interview II, January 26, 2004) identified the following as meaningful to her:

I think that everything that I talked with my mom about and her experiences. That was helpful. I think that having the Lamaze class helped. Knowing the stages [of labor] and how to relax. If I had it to do over again, I would not be induced. I did the best I could, given the circumstances.

Although most of the participants relied on first-hand information from mothers, friends, and their physicians, they used a variety of resources like books, classes, television, and the Internet. Most of the participants indicated a preference for reality television, and books, yet acknowledged distaste for chat rooms.

Knowing: Barriers

Barriers to learning such as lack of time, resources, prior knowledge, irrelevancy, unrealistic expectations, absent support, and poor learning environment have been described in the literature (Caffarella, 1994; Martin & Mamanian, 1991; Kemerer, 1991). When asked several participants overtly identified personal reasons, such as embarrassment, economic concerns, and lack of skill as barriers that prevented them from getting the information they needed.

When asked about her perception of barriers to her learning, Sophie (Interview I, November 19, 2003) described her thoughts and feelings with these words:

I consider being hesitant to ask certain questions to be a barrier. I felt stupid. I did not want to. That is pretty much why, I am not big on talking in class [Lamaze Childbirth Preparation]. I did not ask it [my question] in class anyway. That is pretty much it. Because one time in Lamaze class, my question was answered with “Well, if it is breech you will do all of these positions that we just talked about two minutes ago!” I felt dumb for asking it. In Lamaze class, she [childbirth educator] will ask, “Do you have any questions?” That is never when I have a question. It is when she is in the middle of doing

something, I will think of something. I did ask a couple of questions this week, yesterday. She answered them when I asked.

Even though Sophie was successful in having her questions answered, she seemed to have lingering concerns about asking a question at the right time. Based on her personal experience, she had learned that by thinking too far ahead or behind, instructor and student could offset their synchronization, and then increase the risk of not getting the information she needed.

Jenn (Interview I, November 24, 2003) reflected these thoughts regarding her personal discomfort as an impediment she encountered in getting the information she needed:

I could see where, except with my mom, modesty, embarrassment, and that sort of thing. I have always been shy. This [pregnancy] has made me go out of my boundaries as far as asking questions. Generally, beforehand with my doctor it was like, get me in; get me out! I don't have any questions. I don't want to talk about this. Now, it is forced on me. This is what is going on and why. I have been asking the doctor more questions. There is always the sense that it is just me; no one else has ever had this problem or this issue or this question. It is such a personal thing . . . it is not that I believe that this is information that I should know.

Clearly, pregnancy has put Jenn in a position that she is forced to ask questions of her male physician. Perhaps because Jenn does not feel comfortable asking questions or does not have resources other than her doctor, such as friends, her feelings of isolation compound or even escalate her feelings of knowledge being forced on her. It is painful for her to have to ask for the knowledge, yet she does not feel this is information she should already possess.

Olivia (Interview I, October 24, 2003) gave this explanation of barriers to learning about childbirth.

The expense that might be prohibitive for some people. The classes here at the student center go up to \$200.00. I am not sure what kind of class it is; I know it is long term. It is over two or three months. I thought that would really have an effect on who would be in the class because of the cost. Also, if people did not have access to the Internet, maybe resources for finding books. We are on a budget . . . I don't get the magazines. I get the free ones in the mail and a couple of books we have invested in. That is kind of a barrier to getting knowledge, not being able to afford every book that might be interesting. The fear of embarrassment over certain things you are not told about and you worry about how you present yourself to your doctor that may prevent people from asking about if it were occurring.

Erin's thoughts and feelings about barriers to knowledge surrounding the birth process are revealed in her following statements (Interview I, January 6, 2004):

Sometimes I cannot find exactly the detail that I am looking for or maybe it is not in a layman's website. For example, we had an amniocentesis and I wanted to, before we had it, I wanted to go in and find out what are all of the possible problems that they could find . . . With the amniocenteses, it is not that straightforward. They are doing a comparison to see if there are any abnormalities. But I really wanted to have, ideally I would have liked to have a list, here are all the things that they could come back and say, that way I could be prepared if they did come back and say she had one of these conditions. I could not find that information very easily. I spent hours and hours in all sorts of different websites. The one book I have gave some of the main ones, Downs of course. But I really did not feel like I could get to that information or even a good understanding of the whole testing process . . . What are they going to do and how are they going to test it. It is

probably there; it is just something that I could not recognize. I don't have that experience; I don't have that knowledge that someone in the medical profession would have. So that I felt, maybe it is my own lack of understanding that kept me from getting that detail of information that I needed. . . . I am sure I could call the doctor, which would be the last thing. . . . I suppose that is when I call the doctor and say, "Is this normal?" The information is not there how I want it. That inhibits me from getting the information that I think I need. I tend to get a little bit frustrated, and I don't like to go out there and just search I like to go to a website, like go into WebMD and type in the search in there. Not go to Google or Yahoo because you get everything and get stuck in these chat rooms and I get back to the people who do not know what they are talking about.

While many of the participants described personal reasons, such as embarrassment, financial limitations, and a lack of technical skill as barriers in their learning environments, from previous text, there is evidence of an environment surrounding pregnancy that provides an atmosphere of improbable transfer of learning, key caregivers that are hostile, and a nonsupportive environment for knowledge application.

Summary

In chapter four, I provided a description of the participants, demographic information, and examples of their experiences of learning about birth. I interviewed nine expectant, first-time mothers. This is a small, non-representative sample of women. Variations were noted in their ages, education preparation, ethnicity, living arrangements, and how they planned to learn about giving birth. They ranged in age from 18 to 36. Clearly, most of the participants valued knowledge surrounding the birth experience and actively sought information as they expressed

their thoughts and feelings. Information was sought more aggressively, the closer to delivery they were. Even though some of the participants sought and seem to understand their knowledge, in many cases it left them in a state of discontent.

The first theme uncovered was *Knowing: Responding to Pregnancy*. The expectant mothers were forthcoming in their descriptions of their pregnancy. Most often, they expressed the ability to reframe their discomforts associated with pregnancy within a positive context. Two expectant mothers identified their pregnancies as miracles. Less than positive responses seemed to be correlated to reactions by family members.

Unknowning: Disquieting Intuition emerged as the second theme. All participants expressed varying degrees of their perception birth wisdom. This knowledge is one that is largely distrusted or not acknowledged by the participants. Intuition about birth was regarded as natural and something to be acquiesced. Three of the participants attempted to correlate their birth intuition with previous life experiences, especially those surrounding pain.

Expecting Birth with a sub theme of *Control* was a well-documented theme with over nine examples from the participants. Control related to knowledge dissemination, communication, labor, and birth was illustrated in issues related to the participants' acquisition of birth knowledge.

Hope evolved as another sub theme based on the interview narratives. Five expectant mothers gave descriptions of hope founded on their knowledge surrounding their impending births. Hope is viewed as positive coping as it related to pain management and birth options. These participants were able to identify personal choices and mobilize their energy to move toward a positive birth experience.

Another sub theme of *Expecting Birth* was *Conflict*. Conflicting issues contiguous to knowing were revealed by five participants. These conflicts related to their relationships with their health care providers, their bodies' ability to give birth, and their personal expectations.

Connecting and Disconnecting: Mother was a prevailing theme for all participants. The relationship with their mothers was important although sometimes discounted. This relationality ranged from an emotional one to an educational one. All participants expressed the need for help from their mothers in some way. The theme of maternal connection and disconnection permeated other themes as well.

The theme of *Knowing: Birth Story* was a common experience for all the participants with over twelve examples cited. Most found the details to be helpful and three participants felt other women who had given birth should share their experiences with others. Birth story telling created a bond for both the teller and the listener. The need for knowing about the human experience of giving birth was most completely met in this learning environment.

The identification of *Other Sources of Information* emerged as a theme for the participants. Although most of the participants relied on first-hand information from mothers, friends, and their physicians, they used a variety of resources like books, classes, television, and the Internet.

The final theme identified from the narratives was *Barriers to Knowing*. Difficulty in getting information about birth was identified from the textual data. Several of the participants described personal reasons, such as embarrassment, financial limitations, and lack of technical skill as barriers to getting the information they needed. Barriers to knowing and application of knowing were imbedded in all data, but not overtly identified as such by the participants. One example of an imbedded barrier was not having a caregiver receptive to birth preferences.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The purpose of this chapter is to discuss the findings related to knowing in childbirth experienced by first time expectant mothers. The phenomenological investigation will be discussed as it relates to the over-arching research question: What are the experiences of first time mothers in learning about childbirth?

First, limitations of the study that affect validity are addressed. Then the findings are discussed as they relate to existing literature and implications of the study for current theory. Conclusions and recommendations based on the study and literature will follow. In addition, implications for childbirth education and research will be presented.

The uncovering of an expectant mother's experience of learning about birth adds to the richer understanding of the gender-specific experience of knowing in pregnancy and birth. The experience of knowing for an expectant mother has far-reaching social and cultural implications. With the descriptions of those experiences and subsequent explanations, these examples of knowing are a wellspring of data. In support of feminist research, the exploration was done for women.

Limitations of the Study

Several limitations within this phenomenological investigation are noted First, the use of a small, self-selective, and purposive sample mandates that the results are not representative of

all women. Nevertheless, in keeping with the philosophy of phenomenology by including participants who have knowledge of the experience, the findings give understanding to the experience of learning about childbirth for the first time expectant mothers. Of the nine participants, four were twenty weeks or less pregnant at the time of the first interview. The time range between first and second interview varied from four weeks to two months. Four of the participants had given birth at the time of the second interview. Seven of the nine participants expressed the intention to attend, were engaged in, or had completed Lamaze preparation for childbirth classes at the time of data collection.

The phenomenological method of inquiry is not meant to predict. My intentions were to uncover and give voice to expectant mothers' experiences of learning about childbirth. To better understand the issues, concerns, and events surrounding childbirth preparation, I stayed close to the dialogue text to convey events that were significant to the participants.

My experiences as a childbirth educator, nurse, woman, mother, and daughter have influenced the unfolding of the research process. I stayed within the guidelines of the hermeneutic circle to preserve the lived experience of each participant. I made a conscious effort to stay in the primary role of researcher (Benner, 1994; Heidegger, 1962).

To lessen the likelihood of misleading the research process, Peshkin (1988) suggested that the researcher be proactive in dealing with the influences of personal bias and subjectivity. During the interview process, my childbirth educator role came to the forefront. I wanted to facilitate learning about childbirth for the women. I wanted them to make informed decisions. I wanted them to care enough to know what they wanted to have happen during the birth of their child and to try to make that a reality. These were concerns that I knew from my own experience as a woman, nurse, and mother would impact them for the rest of their lives, yet I knew that I

should not cross that boundary. Crossing that boundary and disturbing their coping would create more disharmony for them. They conveyed resolve that I respected and did not wish to disturb. My value of education and active participation in life shaping events had to be checked. I left many interviews feeling sad for what was about to happen and holding the participants accountable for at least part of it. At those points my subjectivity had been challenged. I dealt with these personal concerns by talking with peers and recording my thoughts as I left the interview.

There were times during the second interview, particularly true for those women who had given birth, that I assumed a supportive role. As they described trauma (my word) during their labor and birth, it was clear that they were processing the unraveling of labor and birth in terms of the enormity of their experience. This need to make sense of it was all encompassing. I felt compelled to help them move toward restoration.

The participants, data collection, methodology, and researcher subjectivity all have an impact on the findings of the study.

Discussion

Knowing: Acknowledging Pregnancy

Because pregnancy was the stimulus for learning in this investigation, the acknowledgement of the pregnancy described by the expectant mothers was a significant, intricate process. Family and significant others, in addition to the participants, influenced the foundation for the context of the pregnancy and birth experience, specifically the learning context. Initial conflict existed many times between the participant and her mother for at least four of the expectant mothers. For some of the expectant mothers, this meant a distancing of support at a time they felt they needed it. Excitement and anticipation were identified by two

participants. The seeking of outside support from other women, who have given birth, especially from your own mother, is an important milestone of pregnancy and early mothering, especially for these participants. These networks provide safe environments for the expectant mother to explore her fears and to start identifying instinctive behaviors related to giving birth (Davis-Floyd 1992; Seibold, 2003; Stern & Bruschweiler-Stern, 1998; Zwelling, 2000).

The data gathered from the investigation supports the research results of Melender and Lauri (2002) and Tarkka and Paunonen (1996) who determined that friends and relatives have been shown to help the expectant mother cope effectively during pregnancy.

Another component of seeking acknowledgment was in dealing with the discomforts of pregnancy. Four of the expectant mothers participating in the study were able to reframe their discomfort, despite the potential distress, and view their pregnancy as positive. If the experience of pregnancy was viewed as healthy and positive, then the participant responded with healthy behavior. If the expectant mother viewed her pregnancy as an illness, then she considered the discomforts as major inconveniences (Zwelling, 2000). This polarized view of pregnancy evolves from the medical model versus the midwifery model of care. The medical model views pregnancy as an illness, something needing to be repaired, while the midwifery model considers pregnancy and childbirth as a normal, healthy life event (Baldwin, 1999; Davis-Floyd, 1992).

The results of the present study are consistent with Schneider's (2002) qualitative investigation using a grounded theory approach to the investigation of Australian women's first pregnancy experiences. The participants experienced difficulty coping with the physical symptoms of pregnancy. Their perceived loss of control was a stressor and the participants felt the need for supportive direction from significant others.

Unknowing: Disquieting Intuition

The second theme derived from participant interviews and journals was “Disquieting Intuition.” This theme is in many ways paradoxically related to the others. It became clear from the interviews that participants acknowledged their physical capacities related to pregnancy, but they were hesitant or unable to recognize their intuition. The first time expectant mothers explained that the concept of intuition related to birth was not well formed for them. Several participants denied having any inner wisdom at all. The data is supported by the Melender and Lauri (2002) investigation of factors related to security for pregnant women. The first time mothers in the sample indicated that did not have knowledge based on personal experience. This finding is in contrast to the belief held by Lamaze International (2000) that women possess an inner wisdom as it relates to birthing.

Intuitive knowing is often described as a universal human experience fundamental to the knowing process. Intuitive knowing has many obstacles that originate from an American demand for scientific problem solving. Additionally, the belief that intuition is exclusive to women, that it is not accompanied by reliability, and how it interplays into the scientific domain may be barriers as well (Belenky et al., 1986; Burnard, 1989; Miller & Rew, 1989; Mitchell, 1994; Ruth-Sahd, 2003; Seibold, 2003).

The idea that the participants minimized or denied their intuition is evidenced by their hesitancy to discuss their inner knowing (Zelman, 2002). When intuition is used, it is in an attempt to understand the uncertainty of the ever-present, ever-changing reality in today and tomorrow. Birgerstam (2002) states that the interplay between rational, logical thinking and intuition creates more value in the learning process, however, the data from the present study does not support this value. The expectant mothers in this study denied their knowing as it

related to birth.

If an expectant mother is making real choices, a process of sharing and negotiation of information will facilitate that decision making process. Informed decision making about choices in childbirth necessitates that women must first have the information they need to make their determination. Even if an expectant mother has the information, a spirit of cooperation must exist between the participant and her health care provider for that knowledge to be valued (Campbell, Thompson, & Lavender, 2002; Madi & Crow, 2003; Tran, Haidet, Street, O'Malley, Martin, & Ashton, 2004).

Sources of knowing are as diverse as is knowledge itself, for example, empirical evidence, professional ethos, or intuition (Davis, 1997). Inherent in authoritative knowing, based on empirical evidence, is the hierarchal relationship. The expectant mother may presume that her health care provider knows what is best for her. Any resistance to this ordering risks that person being labeled as abnormal or on the fringe. The technocratic model founded on authoritative knowledge, is a means of asserting control over the expectant mother (Stewart, 2001).

Mary Stewart (2001) used a qualitative approach to better understand how health professionals, midwives, and physicians, in childbirth services viewed evidence. The impact of the dominant culture was seen as one created by the health care professionals as a means of fostering a system that asserted authoritative knowledge. The participants of this study confirmed that they were going to yield to the health care professionals and not portray themselves as knowing more. Even though one participant approached her physician about negotiating a birth plan, it was so poorly received that the experience became a pivotal point for her changing doctors.

Expecting Birth: Control

Relationships with family members, mothers in particular, and health care providers, that withheld or controlled information while the participants were growing up or seeking care were a source of tension for the expectant mothers. Participants' feelings ranged from disappointment to frustration at this exertion of an external locus of control. Four participants acknowledged the struggle they experienced in maintaining a positive relationship with their health care provider. They did not want their knowledge to jeopardize that relationship or care they would receive. Only one expectant mother was so frustrated with her physician's unwillingness to openly discuss her birth plan that she found another physician in her last month of pregnancy. One study on informed consent indicated that if an expectant mother makes a decision from a position that she believes is one of power and understanding, then she will consider her views as being respected (O'Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002).

Another reason for feelings of frustration relate to lack of control, lack of knowledge, and a negative view of the health care provider as specified in Fowles (1998) study to understand the lingering concerns of women who had given birth. Green (1999) takes issue with the concept of control for a woman in childbirth, "for many women it is likely that the belief that 'they know best' –that one is being cared for by experts –is essential to the feeling in control" (p. 52). The expectant mother believes she has a choice that enhances her sense of control. Arguably, a woman who delegates her decision-making may also feel a sense of control.

Two studies described the importance of control for the participants. Using a phenomenological approach, Gibbons and Thomson (2001) interviewed eight expectant mothers and found that they all wanted to have an active role in the birth of their child. In the correlational study conducted by Goodman, Mackey, and Tavakoli (2004), personal control was

a significant predictor for total childbirth satisfaction in 60 low-risk postpartum women.

Even though two expectant mothers were under the care of midwives, all of the expectant mothers were giving birth in hospitals that operate under the medical model. Because of the birthing environment chosen, they have an increased likelihood for confusion and anxiety related to their birth experience. The prevailing belief by participants, that any attempt at control of labor is futile, is consistent with the findings of Armstrong and Feldman (1990), birth with its own agenda will ultimately sabotage any attempt to control it.

Cleeton (2001) qualitatively examined college student's responses to watching a birth video. Her findings showed a wide range of awareness and knowledge among the participants. Cleeton felt that high school students' lack of knowledge about birth contributed to their fear. Students should be taught specifics about birthing to reduce anxiety and increase maternal control. The finding associated with the relationship of not having formal knowledge and having fear is not consistent with the findings in the current study. The majority of expectant mothers in this study had formal knowledge and still identified fear as an issue for them. Perhaps the closer one gets to the act of giving birth the less control one feels or the less need to feel in control.

Although concerns about pain permeated every conversation with participants, the pain of childbirth is a natural response to the complex physiology of labor. The words of these expectant mothers demonstrated interpersonal conflict as it related to their anticipation of pain.

Expecting Birth: Hopefulness

Feelings of hopefulness surrounding the anticipated birth were described by the majority of the participants. They described the process of learning about options that were available to them. These options, in turn, caused them to be hopeful that were going to experience the situation of staying home in early labor, resting with pain management during active labor, in a

supportive birthing environment.

Using a descriptive, qualitative design, Seibold (2003) examined young pregnant women's experiences of embodiment, identity formation, and decision-making. All expectant mothers embraced the physical changes associated with their pregnancy. Their mothers, in particular, enhanced their own acceptance of the pregnancy. Hope for a positive future, in addition to access to classes, books, and the media improved their acceptance.

While a realistic view of birth is important, a sense of hopefulness was articulated by some of the participants. To better understand Chinese women's perceptions of birth, Ip, Chein, and Chan (2003) surveyed Chinese pregnant women, the majority of whom had not attended childbirth education classes and had high expectations of support from both their partners and midwives during labor and delivery. Conversely, expectations toward their own ability to cope with pain were relatively low. Additionally, the expectant mothers verbalized concerns about labor pain and indicated low expectations about minimal use of medical interventions during labor. The researchers concluded that childbirth education classes should help expectant mothers develop realistic and positive expectations.

After learning about birth options, the participants verbalized thoughts of personal choice that enabled them to express specific feelings of hope toward the birth of their child. Their verbalized anticipated birth experiences were realistic, yet their words were embedded with feelings of doubt as to the achievement of their aspirations.

Expecting Birth: Conflict

Historically, decisions surrounding birth have been made by women from active and aggressive positions that have shaped birthing for generations. These decisions were made with good intent, most often arising from the intense realities of birth (Armstrong & Feldman, 1990).

The findings of the current study support previous findings from Lazarus (1997) that knowledge does not empower women to speak for themselves and identify preferences for birth with their healthcare provider and Butani and Hodnett (1980) who determined that a woman in labor needed to maintain self-control, to live up to her expectations, and to preserve her self-esteem.

Atkinson's (1957) explanation of expectancy learning theory describes motivation for the learner as an impetus to act from a desire to reach success or to avoid failure. Eight of the nine mothers expressed the need to have a positive, safe birth. Within these participants, motives varied, not without conflict, with the majority seeming to lower their personal expectations and responsibility to avoid failure.

Expecting Birth: Confidence

In an exploratory study by Spiby, Henderson, Slade, Escott, and Fraser (1999), there was a determination of high percentages of confidence in pregnant women who used coping strategies learned in childbirth class. The convenience sample of 121 women came from the United Kingdom.

Crowe and von Baeyer's study (1989) determined that expectant mothers who displayed greater knowledge of childbirth and higher confidence after prenatal class reported a less painful birth experience. The authors believed their findings supported the emphasis in prenatal education on imparting knowledge, giving confidence, and dealing with fear related to childbirth.

The findings from the interviews of nine expectant mothers, seven of whom were attending or had attended childbirth education classes, indicated a wide variation in levels of birth confidence. The interview quotes support a picture of high birth confidence in their ability to physically labor and give birth. This finding of a high level of confidence in the physicality of birth coupled with the finding of an almost absence of birth wisdom seems to undermine any

perception of confidence. However, this paradox may be a result of the prevailing power of the medical model and the dominant role it plays in these expectant mothers' lives.

Saisto and Halmesmaki (2003) asserted that a common reason women fear childbirth is that they fear being incapable of physically giving birth. This is in sharp contrast to the finding in this study that the majority of expectant mothers proclaimed a physical capability to birth their baby.

Connecting and Disconnecting: Mother

Sharing their personal domain of pregnancy with their mothers is an example of intimacy that bids relationality. Human connectedness gives life purpose and meaning. All nine participants spoke of the importance of the relationship with their mothers at this time. There was evidence of discounting information from their mothers primarily because they had given birth so long ago, yet most expectant mothers indicated their mothers were influential in their pregnancy and birth. Mothers of the participants were present for two of the four births of the women who gave birth during data collection. All four mothers of participants who delivered came to help their daughters after delivery. The expectant mothers all were pleased that their mothers attended their births. One participant indicated she received an epidural because her mother wanted her to. The issue of an enmeshed mother-daughter relationship to the exclusion of the husbands was also identified in the narratives.

No prior studies have identified this relationship as a finding. While it may be tempting to attribute the strong mother-daughter relationship to the culture of the region, four of the participants did not grow up in the study area. Because embarrassment was identified as a barrier, perhaps the participants felt the least embarrassed in confiding and exploring with their own mothers.

Knowing: Birth Story

Void of memory of receiving substantial information about childbirth as children, the experience of hearing birth stories was universal for the participants. Some of the participants expressed a need to hear other's stories. Birth storytelling is well documented as an effective way for expectant mothers to learn about birth (Armstrong & Feldman, 1990; Davis-Floyd, 1992; Drake, 2002; Leight, 2002; Livo & Ruitz 1986; McHugh, 2001; Razak, 1993; Sargent & Stark, 1989; VandeVusse 1999; Zwelling, 2000). The development of personal knowing through mutual relationality may be facilitated through storytelling to fully comprehend the storyteller as if the listener were inside her world (White, 1995).

Knowing: Other Sources

The participants in this study identified a variety of sources for information, direct and indirect. The expectant mothers preferred to use their mothers, physicians, books, childbirth classes, Internet, and television reality programs for information and knowledge about childbirth. These findings are supported by previous studies (Mackey, 1990; Maternity Center Association, 2002; Stamler 1998).

A more recent study concerning information resources was conducted by Levy (1999) using a grounded theory approach to investigate how women used information to make informed choices. The participants were twelve midwives practicing in the United Kingdom. Midwives were observed to guide their patients through available birth options that were perceived to be mutually safe, realistic, and acceptable.

Australian research on pregnancy and childbirth has determined that expectant mothers access information from media, books, magazines, pamphlets, midwives, and parenting classes. Specifically advice from friends and healthcare providers, books and pamphlets (Department of

Health, 1990). The information was considered important if the participant valued the informant.

A recent report from Britain, a national survey of women's views of maternity care (Garcia, Redshaw, Fitzsimmons, & Keene, 1998), indicated that women want good information about childbirth and the chance to learn more as needed. Because there is uncertainty surrounding the issue of birth for these participants, valued knowledge from culture, other mothers, classes, television, and books brings the demands of childbearing to life (Ewy-Edwards, 2000). These studies support the findings from this research.

Knowing: Barriers

Barriers identified from the interviews included personal reasons such as embarrassment, financial limitations, and lack of personal skill in finding resources. Although these were identified as barriers, the participants were able to obtain the information they were seeking. This finding is supported by the study conducted by Al-Lawati and Hunsaker (2002) who qualitatively explored the implications of the development of five women from Islamic culture. The researchers determined that five major components were instrumental in the development of participants: social motivation, spiritual motivation, and need for change, role for study and learning, and barriers. The interview data uncovered the struggle, personal and social, the participants underwent to make changes in their lives. None of the barriers impeded the women from moving forward though it created tentativeness.

These findings also share similarities with Marion Bowl's (2001) study of 32 nontraditional female learners; she relayed the stories of three participant's experience of barriers in education. Key barriers were identified as lack of family support, need for support and guidance, frustration by participants, and anticipating change.

The experience of learning about childbirth shares many parallels with the findings from

Kilgore and Bloom (2002). The researchers examined the stories of women in crisis and its effect on learning. The crisis context for the participants was prison. Story themes included short-lived transformation. The researchers learned that women in crisis experience powerlessness and consequently submission, an acceptance of fate. The system dictated what to do and how to do it to create discipline. Comments like “I just did it” validated that perception. One finding surrounded the notion of disorienting dilemmas as a threat to knowing. When an experience of learning occurs in a way different from what is known, it has the potential to be a positive transformation. However, if there is disagreement in context, a resistance to knowing, a refusal, transpires (Taylor, 1998). Knowledge is a constant state of becoming, knowing. Women in crises also include women who are pregnant, in labor, and giving birth. Certainly, the authoritative position would have us to believe so. My findings also demonstrate that fear prohibits active participation in discourse.

Conclusions

From the findings of the present study and literature reviewed on the experience of knowing in childbirth for expectant mothers, the following conclusions resulted. The lack of children’s literature and withholding of information from family may have a negative impact on a child’s perception of the childbearing process. The lack of information that would be age-appropriate lends an air of mystery to those events associated with being pregnant and giving birth. What they have been told, not been told, and the manner in which the information was conveyed influences women of all ages as they make choices about their lives.

Even as pregnancy is an exciting time, there are also feelings of confusion, conflict, and control. No matter how well substantiated the information is, confusion exists concerning information that is received about childbearing (Treicher, 1990). The expectant mother must

juggle a myriad of factors as she begins making decisions, conscious, and unconscious, about what she wants to have happen. Yet, some women will make final decisions primarily based on what their mothers or doctors tell them or want them to do. The importance of an expectant mother's own mother in the childbearing process has been largely overlooked in the literature, but the present study findings suggest that the mother-daughter relationship plays a major role in childbearing.

Expectant mothers know they must "birth" their babies. They physically have to do it. They possess little or no substantial, trustworthy intuition about their knowing connected to the birthing process, even after they have given birth.

Implications for Childbirth Education and Research

The findings of this study provide direction for needed changes in childbirth education. Childbirth educators must acknowledge the significant and powerful relationship that exists between an expectant mother and her doctor and between an expectant daughter and her mother. Almost non-existent was the recognition of the nursing role for the mother during labor and delivery. Skills to negotiate within and around those relationships should be taught if the expectant mother desires a woman-centered birth.

It is noted from this study, the need for childbirth educators to assist and therefore support the expectant mother in her decision-making process. To help her understand the motivation underlying her decisions and consequently whose best needs are being met, an open learning environment must be established.

Additionally, because expectant mothers are at risk for disappointment and depression, it is recommended that the childbirth educator help the expectant mother develop a realistic, flexible plan for birthing. Inherent in this process, is an understanding of how much of an active

role this mother wants to take in her birth experience.

Schools of nursing may want to consider including a women's studies course in their curricula so that nurses working with expectant mothers can understand and fight against the oppression that women may endure and that they may unwittingly foster during the childbirth experience. To undermine the barriers, nursing curricula should also present women-centered care in their undergraduate and graduate maternity nursing courses (Giarratano, 2003).

Having information about childbirth did not necessarily lower anxiety and eliminate conflict for the expectant mothers in this study. In fact, conflict and confusion may have actually increased as they experienced cognitive dissonance. This evolutionary process of knowing is the first step for the childbirth educator to acknowledge in order to change the learning environment for the expectant mother (Mies, 1999). Programs for certification of childbirth educators and textbooks for childbirth educators should address this dilemma to assist the childbirth educator to better prepare the expectant mother to deal with this outcome.

Childbirth will always be rich with multifaceted meanings for mothers and daughters. While on a certain level, birth may appear to be natural and normal, it is also embedded with politics that limit real choices women have in childbirth. These limitations undermine any natural or normal characteristics surrounding healthy birth. Are pregnant women who give birth in a medicalized setting marginalized? How do caregivers, especially female caregivers, contribute to marginalization of these women?

Nursing Research

This phenomenological study presents several new research findings concerning the experiences of expectant mothers as they learn about childbirth, but must be seen as an initial effort. The sample of pregnant women was small and limited. A larger study with more diverse

participants from a different geographical location would bring more richness and understanding of women's experience. Data collection using focus groups may increase the spontaneity of the participants.

Based on the themes derived from the interview texts, additional studies could be developed, for example, qualitatively examining the relationship of an expectant daughter and her mother, specific investigation of the phenomena of birth wisdom or intuition for women, and the relationship of knowledge and an enabling birthing environment. In addition, future investigation should examine more thoroughly the relationship of pre-existing knowledge on the birthing experience. To determine educational strategies and teaching methodologies that are most effective in facilitating the transfer of learning to the birthing environment is of extreme importance.

Findings from the literature review and findings of this study support the conclusion that the experience of learning about birth extends well beyond the expectant mother. Even in the presence of physical confidence, there are controlling forces in the expectant mother's environment that are impediments to her knowing: confusion, control, and conflict. What inhibits families and health care providers from being more forthcoming with information about birthing for their daughters and clients? What would a birthing environment entail that encouraged woman to acknowledge, to work with, and to reclaim what they know best about their bodies? How does the voice of the expectant mother reach the same level of importance as the other players involved in her birth process? When will the value of personal knowing approximate that of authoritative knowledge? Childbirth educators face these and other major challenges to assist the mother to transfer her learning to the childbirth experience.

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APPENDIX A
CONSENT FORM

1. Title of Research Study

Knowing in Childbirth.

2. Project Director

Jane Savage, RN, MS, Certified Childbirth Educator; 504-456-9377; 504-568-4170, under the supervision of Renee Casbergue, Professor, department of Curriculum and Instruction, University of New Orleans, New Orleans, LA 70148. Telephone: (504) 280-6530.

3. Purpose of the Research

The purpose of this research is to better understand the ways first-time mothers informally learn about birth. The research problem is: What are the experiences of learning (knowing) about birth for women?

4. Procedures for this Research

Your experience will consist of participating in two interviews that will be audiotaped and transcribed. If you agree to participate, all identifying demographics will be kept confidential. You will select a pseudonym to label your interview. You will receive a copy of the transcript for editing and to give feedback. Each interview should take about one hour.

5. Potential Risks of Discomforts

Participants may experience emotional distress, if recalling unpleasant experiences, or may become tired toward the end of the narrative account. Please keep in mind that all aspects of your participation are voluntary. If you wish to discuss these or any other discomforts you may experience, please call the investigator listed in item #2 of this form.

6. Potential Benefits to You or Others

Participants may experience some cathartic effect by discussing their thoughts and feelings. Sharing the experience may help someone else by giving them insight and skill. This area of

women's knowing will assist health care professionals, specifically, childbirth educators, in understanding the importance women's experience of knowing in childbirth.

7. Alternative Procedures

Your participation is entirely voluntary and you may withdraw consent and terminate participation at any time without consequence.

8. Protection of Confidentiality

The names of all participants will be kept confidential. Participant names will not be identified and pseudonyms will be assigned to the narratives. The signed consent forms, written descriptions, and any other materials related to this project will be maintained in a secure and confidential manner by the investigator. Tapes and all identifiable data will be destroyed when no longer needed. If the results of this study are published, presented at professional conferences, or released to the funding agency used for the study, your privacy will be protected and you will not be identified in any way. Your name will be used only on this consent form. The pseudonym descriptions will be reviewed by the investigators and another researcher to determine themes.

9. Signatures

I have been fully informed of the above-described procedure with its possible benefits and risks and I have given permission of participation in this study.

| | | |
|--|---|-------------|
| _____ | _____ | _____ |
| Signature of Subject | Name of Subject (Print) | Date |
| _____ | _____ | _____ |
| Signature of Person Obtaining Consent | Name of Person Obtaining Consent (Print) | Date |

APPENDIX B
INTRODUCTION LETTER

Dear _____ :

I am a doctoral candidate in the College of Education at the University of New Orleans. As partial fulfillment of the doctoral requirements, I am planning to conduct a study concerning expectant mothers. The purpose of the study will be to describe the experience of expectant mother's perception of their wisdom relating to childbirth. Your participation in the study is requested because you are experiencing your first pregnancy.

Participation in the study will require approximately 2 hours or less of your time for an in-depth interview and an additional hour for a second interview. The interviews, with your permission, will be taped and transcribed. To maintain confidentiality, you will not be identified on tape or in the transcript. I will ask you to select a pseudonym for reference. I will transcribe the tapes. Each transcript will be read by an outside reader; this person will know you only by your pseudonym. The tapes will be locked in my file cabinet in my office at Louisiana State University Health Sciences Center School of Nursing. Each participant will be offered a copy of the transcript.

A comparable amount of time will be required for journaling. I will provide you with a journal to record your thoughts and feelings during your pregnancy. From time to time, I will ask you to mail your journal to me in a postage paid envelope. I will transcribe your entry and return the journal to you. The journal is for you to keep.

In the next week, I will be contacting you to answer any questions you may have concerning your participation in this study. At that time, we can arrange a meeting to discuss the details of the interview process and the consent process. Enclosed for your review is a copy of the consent form.

I appreciate your thoughtful consideration of my request. I look forward to your participation in the study.

Sincerely,

Jane Savage, RN, MS, LCCE, FACCE
Email: jsavag@lsuhsc.edu
Office Phone: 568-4170; fax 568-8294

APPENDIX C

INTERVIEW QUESTIONS AND DEMOGRAPHIC FORM

Questions for Interview and Demographics

1. What do you remember hearing about childbirth as a child?
2. Who were the tellers of those stories?
3. Describe the people in your life who have given you information about childbirth.
4. What facilitated the acquisition of this information? How did you feel after hearing the information?
5. What were the barriers to your obtaining birth knowledge?
6. Describe how you believe your knowledge will be accepted and valued by whom in your childbirth process.
7. How will your wisdom affect your relationship with your health care provider, your birth experience?
8. What do you imagine will happen during the birth of your baby?
9. What will be your role during the birth of your child?
10. How will you get the knowledge you need to have your baby?
11. Tell me about the reasons you have for attending or not attending childbirth classes.
12. Women who trust their body's ability to give birth seem to have an intuitive sense that guides them. How would you describe yours?
13. Describe your experience of obtaining this wisdom.
14. Describe any life experiences that you have had that you believe will assist you in giving birth.

VITA

Jane Staton Savage was born in New Orleans, Louisiana. She spent her childhood in Hattiesburg, Mississippi. Jane received both her Bachelor of Science in Nursing and Master of Science in Nursing, specialty, Mental Health, degrees from the University of Southern Mississippi. She has worked as a staff nurse in medical surgical nursing and all areas of maternal child nursing. For over 25 years, Jane has taught undergraduate nursing. First at Mississippi College in Clinton, Charity Hospital School of Nursing, New Orleans, and at Louisiana State University Health Sciences Center, New Orleans.

Jane is certified by Lamaze International to teach Lamaze childbirth preparation classes. In 2001, she was honored to be selected by Lamaze International as a Fellow in the American College of Childbirth Educators. Jane is married to Steven Savage. They are the proud parents of two daughters, Jennifer and Kelley.